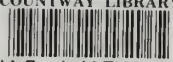


COUNTWAY LIBRARY

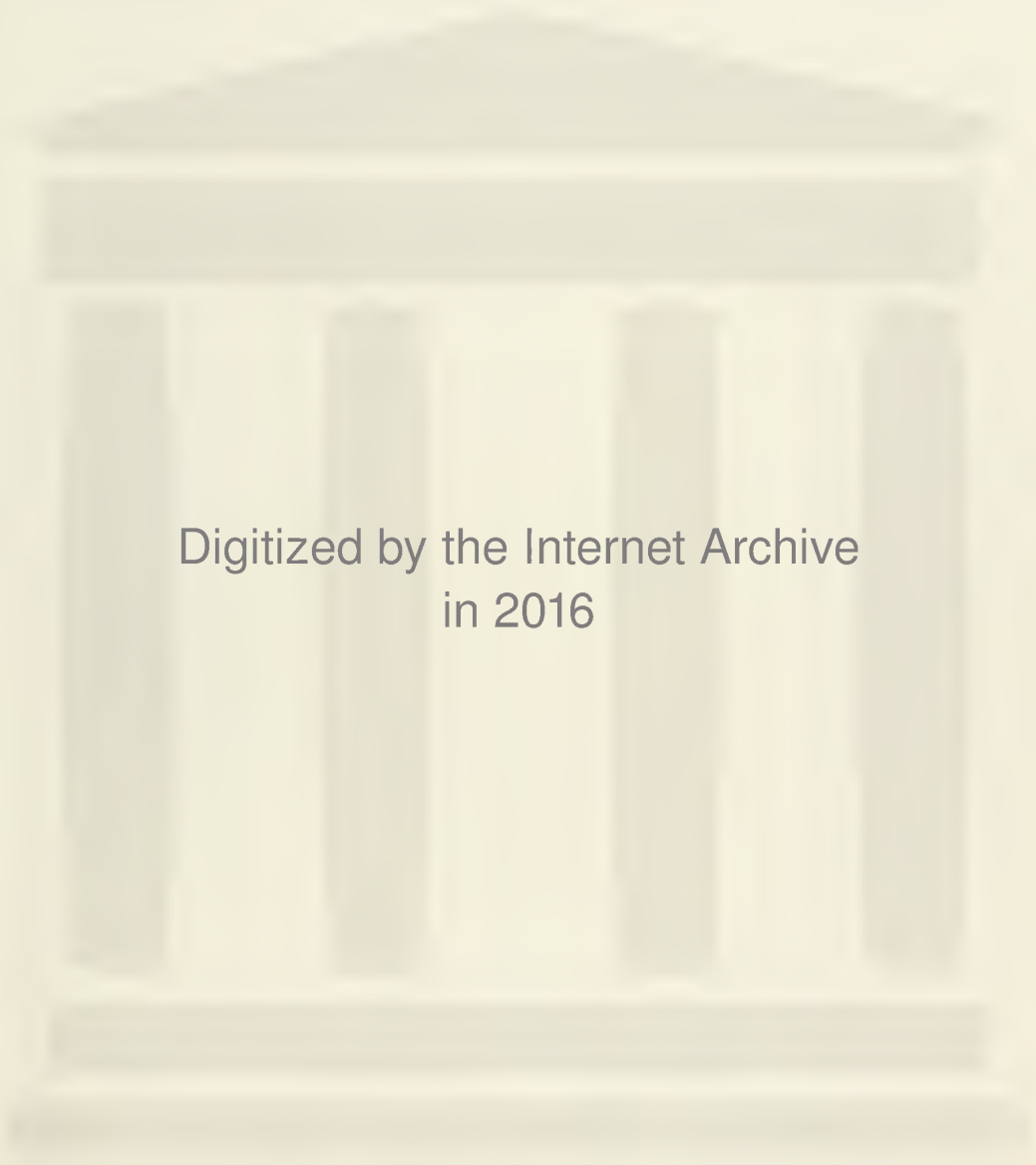


HC 4KBW A

BOSTON
MEDICAL LIBRARY



IN THE
Francis A. Countway
Library of Medicine
BOSTON



Digitized by the Internet Archive
in 2016



COPY 1

PENNSYLVANIA MEDICINE

THE FRANKLIN COUNTY
LIBRARY OF MEDICINE
BOSTON

17 JUL 1968

JULY 1968

DISPLAY
SHELVES



STUDY OF THE
IS VOLUME OF THE
LIBRARY OF MEDICINE
BOSTON

Needs in Pennsylvania

PENNSYLVANIA
MEDICAL
SOCIETY

OCTOBER
27-28-29
1968

COMMITTEE
ON
CONVENTION
PROGRAMS

1968 *Scientific Seminars*

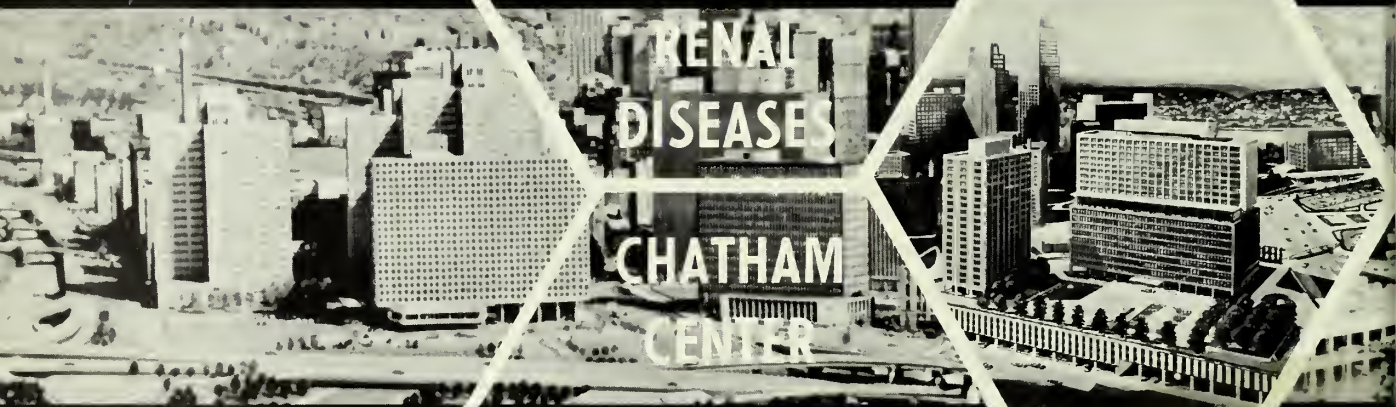
ELECTROLYTE
METABOLISM
AND

RENAL
DISEASES

CHATHAM
CENTER

PITTSBURGH

1968
TECHNICAL
EXHIBITS





PENNSYLVANIA
MEDICINE

/medigram

JULY, 1968

FUTURE SESSION TIME CONSIDERED

Responding to the PMS House action to separate the business and scientific sessions, a committee has determined that Fall still is the best time for business sessions and the House will be asked to approve holding such sessions annually between mid-September and early October. In addition, the Board is recommending that the House approve business session sites for the next five years as follows: 1969- Philadelphia; 1970- Lancaster; 1971- Pittsburgh; 1972- Pocono Manor; 1973- Philadelphia. Next year's Philadelphia meeting will be held in the Marriott Motor Hotel. A socio-economic program will be a part of each business session.

COUNCIL CHAIRMEN NAMED

The PMS Board of Trustees has approved the appointments to administrative councils made for the 1968-69 society year by the President-Elect, George E. Farrar, M.D. The new council chairmen and vice chairmen, respectively, are as follows: Governmental Relations- Paul S. Friedman, M.D. of Philadelphia and John H. Harris, Jr., M.D. of Cumberland County; Medical Service- Matthew Marshall, Jr., M.D. of Allegheny County and J. Eugene Ruben, M.D. of Philadelphia; Public Service- R. William Alexander, M.D. of Berks County and Walter I. Buchert, M.D. of Montour County; Scientific Advancement- Richard B. Magee, M.D. of Blair County and Ralph K. Shield, M.D. of Northampton County.

PLANNING ACTIONS TAKEN

The name of the PMS Commission on Health Facility Planning has been changed by the Board of Trustees to the Commission on Comprehensive Health Planning to reflect more accurately its responsibilities. The PMS also has asked the Secretary of Health to consider having the Commission serve as a medical advisory committee to the state's Comprehensive Health Planning Advisory Council.

CHANGES AT HEW

HEW Secretary Wilbur J. Cohen announced several changes in HEW personnel. Herbert L. Ley, Jr., M.D., Director of the FDA's Bureau of Medicine since 1966, succeeds Dr. James L. Goddard as Commissioner of Food and Drugs this month. Dr. Ley's appointment does not require confirmation by the Senate. James H. McCrocklin, M.D., President of Southwest Texas State College, has been nominated by President Johnson to fill Mr. Cohen's former post as Undersecretary of HEW.

NEW MEMBERS APPOINTED TO THE STATE BOARD OF MEDICAL EDUCATION AND LICENSURE

M.D. to become new members of the State Board of Medical Education and Licensure. Dr. Robertson replaces Dr. James C. Giuffre and Dr. West replaces Dr. Harry C. Winslow.

The Senate confirmed William B. West, M.D. and John W. Robertson,

GOVERNOR SIGNS IMPORTANT AIR POLLUTION CONTROL BILL

The Governor signed H-926 which was the Administration-sponsored and PMS-endorsed amendment to the "Air Pollution Control Act". The bill clarifies the Commonwealth declaration of policy and clears up the definition of air pollution which was a legal debating point. It also gives the Department of Health additional authority to issue compliance orders and changes the composition of the Commission and further clarifies its responsibility. In addition, the Act (No. 92) clarifies the rights of citizens to obtain relief from air pollution problems through private litigation. The new declaration of policy is interesting, and so we quote: "It is hereby declared to be the policy of the Commonwealth of Pennsylvania to protect the air resources of the Commonwealth to the degree necessary for the (1) protection of public health, safety and well being of its citizens; (2) prevention of injury to plant and animal life and to property; (3) protection of the comfort and convenience of the public and the protection of the recreational resources of the Commonwealth, and (4) development, attraction and expansion of industry, commerce and agriculture." Air pollution in the new law is pinned-down as "the presence in the outdoor atmosphere of any form of contaminate, including, but not limited to, the discharging from stacks, chimneys, openings, buildings, structures, open fires, vehicles, processes, or any other source of any smoke, soot or flyash, dust, cinders, dirt, noxious or obnoxious acids, fumes, oxides, gases, vapors, odors, toxic or radioactive substances, waste, or any other matter in such place, manner or concentration inimical, or which may be inimical to the public health, safety or welfare, or which is, or may be, injurious to human, plant or animal life, or to property, or which unreasonably interferes with the comfortable enjoyment of life or property."

NEXT MONTH

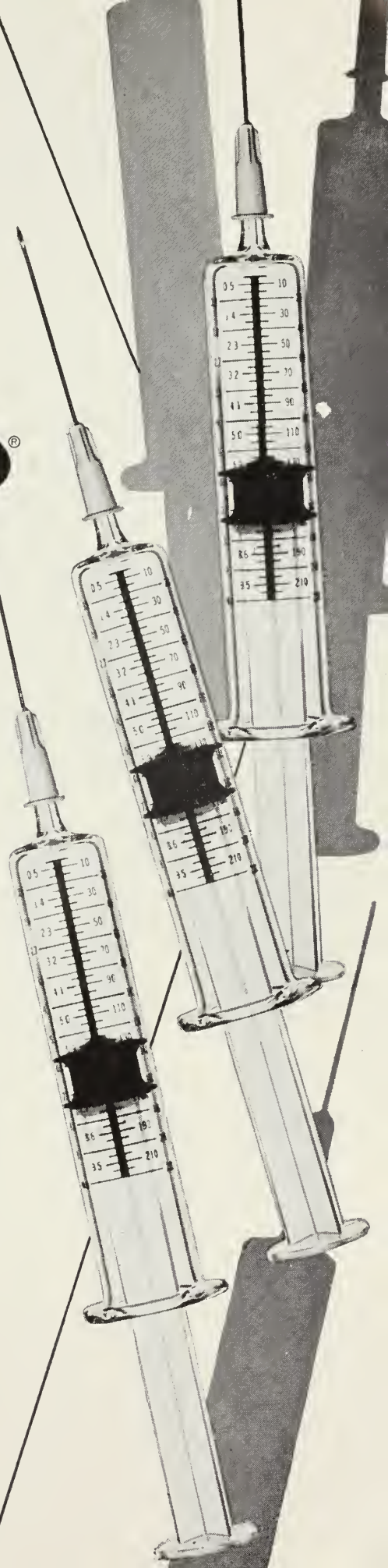
DATELINE: KHE SANH -- PENNSYLVANIA M.D.'S IN COMBAT

In a story written on the battlefield exclusively for PENNSYLVANIA MEDICINE, three Commonwealth physicians currently on active duty with the United States Navy, tell their own exciting story of the practice of medicine in combat.

BSP[®] DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor—the most costly commodities.

BROMSULPHALEIN[®]
IN A COMPLETE,
STERILE,
DISPOSABLE,
& ECONOMICAL
PATIENT-UNIT.

HYNSON, WESTCOTT & DUNNING, INC.



(BSP03)

BALTIMORE, MARYLAND 21201

PENNSYLVANIA MEDICINE®

© 1968 Pennsylvania Medical Society

The Pennsylvania Medical Journal
Official Publication of the Pennsylvania Medical Society

JULY, 1968

VOLUME 71 NUMBER 7

FEATURE

Patient Needs in Pennsylvania	49
-------------------------------------	----

NEWSFRONTS

M.D.s Visit Congressmen	5
Dr. Spaeth Wins Service Award	8
Chest Disease Congress Slated	10
Women M.D. Return Urged	11
Close-up/M.D.s	12
Official Call to the 1968 Annual Session	4
Capitol Report	15

EDITORIAL

Doctor and Nurse	16
------------------------	----

SCIENTIFIC REPORTS

Cardiovascular Briefs	27
Cancer Forum	31

GENERAL

Continuing Education	67
Write Now	70
Obituaries	71
Classified	72
In My Opinion	74

PUBLISHED MONTHLY BY THE
PENNSYLVANIA MEDICAL SOCIETY
TAYLOR BYPASS AND ERFORD ROAD,
LEMOYNE, PENNSYLVANIA 17043

Subscription \$5.00 Single Copy 50¢

PUBLICATION COMMITTEE

Joseph A. Walsh, M.D., Blakely-Olyphant
Chairman
A. Reynolds Crane, M.D., Philadelphia
H. Thompson Dale, M.D., State College
William J. Kelly, M.D., Pittsburgh
Robert S. Sanford, M.D., Mansfield

STAFF

Carl B. Lechner, M.D., 4111 Beech Avenue,
Erie 16508—Medical Editor
Thomas J. McCaghren, Taylor Bypass and
Erford Road, Lemoyne 17043—Man-
aging Editor
Claudia Helsel, Taylor Bypass and Er-
ford Road, Lemoyne 17043—Editorial
Assistant

CONTRIBUTING EDITORS

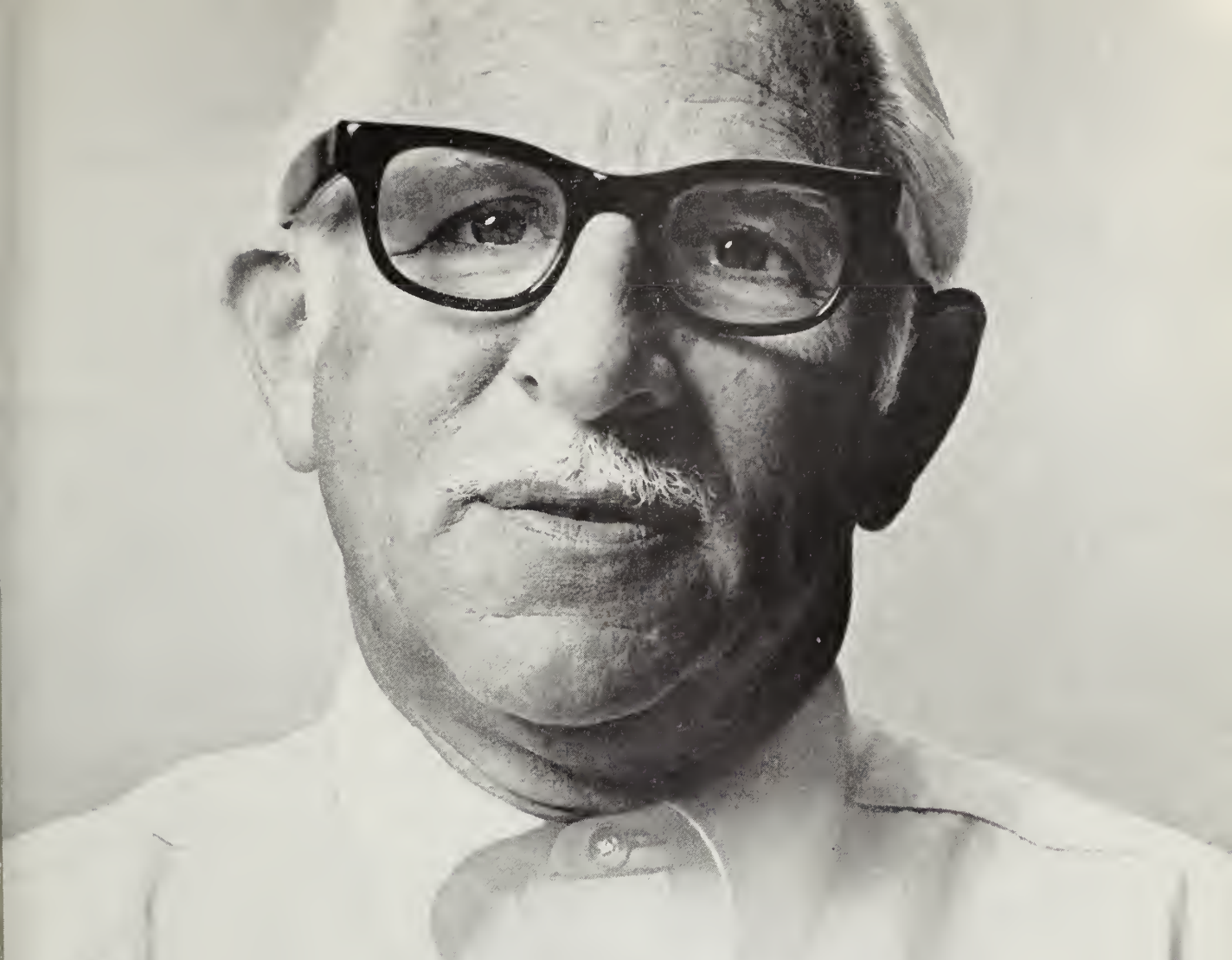
Harry E. Bacon, M.D., Philadelphia
William C. Beck, M.D., Sayre
Walter I. Buchert, M.D., Danville
Lewis T. Buckman, M.D., Wilkes-Barre
A. Reynolds Crane, M.D., Philadelphia
Garfield G. Duncan, M.D., Philadelphia
Mario N. Fabi, M.D., Scranton
George H. Fetterman, M.D., Pittsburgh
Wendell B. Gordon, M.D., Pittsburgh
Samuel B. Hadden, M.D., Philadelphia
Jack D. Myers, M.D., Pittsburgh
Thomas F. Nealon, Jr., M.D., Philadelphia
Eugene P. Pendergrass, M.D., Philadelphia
Mary DeWitt Pettit, M.D., Philadelphia
Sydney E. Sinclair, M.D., Camp Hill
David A. Smith, M.D., Harrisburg
James R. Watson, M.D., Pittsburgh

• **GENERAL.** Established 1897. Penn-
sylvania Medicine may not be held re-
sponsible for opinions expressed in any
of its contents.

• **ADVERTISING.** Pennsylvania Medi-
cine's advertising policy conforms with
principles governing advertising in
American Medical Association scientific
publications. National advertising rep-
resentatives: State Medical Journal Ad-
vertising Bureau, Inc., 510 North Dear-
born Street, Chicago, Illinois 60610.
Advertising rates on request to Penn-
sylvania Medicine office, Taylor Bypass
and Erford Road, Lemoyne, Pennsylvania
17043, or the SMJAB. For classified
rates, see classified section.

• **MAILING.** Second-class postage paid
at Lemoyne, Pennsylvania.

• **CHANGE OF ADDRESS.** Give name,
old address, new address (include ZIP
number), state if change is permanent
or temporary. Send notice to Penn-
sylvania Medicine, Taylor Bypass and Er-
ford Road, Lemoyne, Pennsylvania
17043. Allow six weeks for change of
address.



He is elderly,
he is on corticosteroids,
when he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units

CAPSULE-SHAPED TABLETS Lederle

b.i.d.

guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photo-ergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Con-

stant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity: onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. **Average Adult Daily Dosage:** 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York

Lederle



Official Call to the Annual Session of the House of Delegates

The Annual Session of the House of Delegates of the Pennsylvania Medical Society will convene in Ballroom 1 of the Pittsburgh Hilton Hotel, Pittsburgh, Pennsylvania, at 7:30 p.m., Thursday, September 26, 1968. Subsequent meetings of the 1968 House of Delegates are scheduled for 9:00 a.m. Saturday, September 28, and 9:00 a.m. Sunday, September 29.

Proposed Amendments to the Constitution and By-Laws

Amendments to the Constitution and By-Laws have been proposed by the Committee on Constitution and By-laws in accordance with the provisions of Article XV of the Constitution and Chapter XVII of the By-laws to (1) provide for the Speaker and the Vice-Speaker to serve on the Board of Trustees and Councilors, (2) separate the Scientific Assembly from the Annual Session of the House of Delegates, (3) establish the responsibilities for activities in the area of medical education by providing for a Council on Education, (4) permit the House of Delegates to determine the effective date of amendments to the Constitution and By-laws when desirable, (5) provide specifically for members to appear and speak before reference committees of the House of Delegates.

The text of these amendments is available in the office of the Secretary and will be published in the August issue of *PENNSYLVANIA MEDICINE* and in the Official Reports Booklet distributed to the members of the House of Delegates.

Elections

Among the general officers to be elected by the 1968 House of Delegates will be:

A President-Elect, four Vice-Presidents, a Secretary, a Speaker of the House of Delegates, and a Vice-Speaker of the House of Delegates.

A Trustee and Councilor for the Fourth Councilor District, to serve for five years, to succeed George A. Rowland, M.D., Columbia County, who is eligible for reelection, having served two years of the unexpired five-year term of Joseph J. Leskin, M.D., Schuylkill County, deceased.

A Trustee and Councilor for the Fifth Councilor District, to serve for five years, to succeed David S. Masland, M.D., Cumberland County, who is eligible for reelection, having served one term of five years.

Also to be elected for a two-year term beginning January 1, 1969, will be *six delegates and six alternate delegates to the American Medical Association.*

Delegates whose terms expire December 31, 1968 are:

John S. Donaldson, Jr., M.D., Allegheny County
Gilson Colby Engel, M.D., Philadelphia County
M. Louise C. Gloeckner, M.D., Montgomery County
Park M. Horton, M.D., Susquehanna County
William A. Limberger, M.D., Chester County
William B. West, M.D., Huntingdon County

Alternates whose terms expire December 31, 1968 are:

A. Reynolds Crane, M.D., Philadelphia County
Leo C. Eddinger, M.D., Lehigh County
Raymond C. Grandon, M.D., Dauphin County
John B. Lovette, M.D., Cambria County
Malcolm W. Miller, M.D., Philadelphia County
George A. Rowland, M.D., Columbia County

Also to be elected will be *a member to serve for three years on the Committee to Nominate Delegates and Alternates*

to the American Medical Association to succeed Allen W. Cowley, M.D., Dauphin County, whose term expires and who is eligible to succeed himself.

Also to be elected will be *one member of the Judicial Council to serve for a term of five years to succeed William L. Estes, Jr., M.D., Northampton County, who does not desire reelection after serving four years of the unexpired term of S. Meigs Beyer, M.D., Jefferson County, deceased.*

The Constitution provides that the Board of Trustees and Councilors shall nominate at least *three qualified members to fill the vacancy on the Judicial Council* and nominations may be made from the floor.

Also to be elected, upon nomination of the Board of Trustees and Councilors, will be *two members to serve three-year terms on the Committee on Convention Program* should the By-laws' proposal to dissolve the Committee on Convention Program not receive favorable consideration.

On this basis, the Board of Trustees and Councilors have nominated John H. Moyer, III, M.D., Philadelphia County, and Robert L. Evans, M.D., York County, to succeed themselves for three-year terms as members of the Committee on Convention Program.

Also to be elected is *a District Censor from each component county medical society to serve for one year following the close of the 1968 House of Delegates' session.*

The component county medical societies have submitted the following nominations for District Censor. *Adams*, James H. Allison; *Allegheny*, Robert A. Schein; *Armstrong*, Arthur R. Wilson; *Beaver*, Herman Bush; *Bedford*, Grafious L. Rinard; *Berks*, Ethan L. Trexler; *Blair*, John W. Hurst; *Bradford*, Willis A. Redding; *Bucks*, Stanley F. Peters; *Butler*, (no nomination); *Cambria*, Warren F. White; *Carbon*, James M. Steele; *Centre*, H. Richard Ishler; *Chester*, Irving M. Waggoner; *Clarion*, Theodore R. Koenig; *Clearfield*, (no nomination); *Clinton*, Robert E. Drewery; *Columbia*, Rudolph Szabo; *Crawford*, (no nomination); *Cumberland*, Hans S. Roe; *Dauphin*, Hamblen C. Eaton; *Delaware*, Edward G. Torrance; *Elk-Cameron*, James L. Hackett, Sr.; *Erie*, Joseph M. Faso; *Fayette*, Othello S. Kough; *Franklin*, (no nomination); *Greene*, William W. Bartholomew; *Huntingdon*, (no nomination); *Indiana*, Ralph F. Waldo; *Jefferson*, Nicholas F. Lorenzo; *Lackawanna*, Clement B. Potelunas; *Lancaster*, William A. Atlee; *Lawrence*, Gerald H. Weiner; *Lebanon*, C. Ray Bell, Jr.; *Lehigh*, Frederick R. Bausch, Jr.; *Luzerne*, Donald F. Closterman; *Lycoming*, (no nomination); *McKean*, Ralph E. Hockenberry; *Mercer*, Gilbert H. Diehl; *Mifflin-Juniata*, John R. W. Hunter, Jr.; *Monroe*, (no nomination); *Montgomery*, E. Raymond Place; *Montour*, Isaac L. Messmore; *Northampton*, Walter J. Filipek; *Northumberland*, J. Moslyn Davis, Jr.; *Perry*, William Magill; *Philadelphia*, Charles M. Thompson; *Potter*, Herman C. Mosch; *Schuylkill*, Joseph T. Marconis; *Somerset*, (no nomination); *Susquehanna*, Raymond C. Davis; *Tioga*, Alfred P. Trescott; *Union*, John S. Purnell, Sr.; *Venango*, (no nomination); *Warren*, Robert D. Donaldson; *Washington*, Ralph S. Blasiale; *Wayne-Pike*, (no nomination); *Westmoreland*, Leslie S. Pierce; *Wyoming*, (no nomination); *York*, William C. Langston.

This Call to the Annual Session of the House of Delegates has been issued this 27th day of May, 1968.

Allen W. Cowley, M.D., Secretary



newsfronts

Communication Link Tied

Pennsylvania M.D.'s Visit Nation's Capital; Meet Congressmen

State Practitioner Deemed Keystone In Medical Rulings

Will American doctors become paid employees in a government monopoly on medical services?

The prospect is frightening; the possibility of eventual federalization in all areas of medical practice is real.

That the government is exerting a more active interest in the costs and delivery of medical care is nothing new to the doctor. How far the tentacles of control will extend into a traditionally free enterprise, how great an inroad will be made in the establishment of national standards and national programs in the practice of the healing art remains an unknown quantity at this writing.

What Pennsylvania physicians learned during a visit to their Congressmen in the Nation's capital last month was a candid revelation that they, and they alone, are the keystones of influence in medical legislation.

The Pennsylvania delegation of physicians was one of twenty medical pilgrimages from various states to Washington, D.C., this year for the purpose of developing a better line of communication between the practitioner and the politician.

During the one-day visit, Commonwealth physicians received an early-morning briefing on the current political scene by representatives of the



Maurice Kramer, AMA Lobbyist in Washington, D. C., speaks at the breakfast session.

AMA Washington office, conducted private visits with their Congressmen on the Hill, dined with them in the Rayburn House Office Building and later held a post-mortem on the day's activities.

Lag Noted In Health Legislation

At the breakfast conference, Rex Kirkley, M.D., assistant manager of the AMA Washington office, reported to Pennsylvania M.D.'s that the mood of Congress today reflects a great sense of frustration over the situation in Vietnam, civil unrest, the balance of payments, the prospect of dollar devaluation, deficits and the tax bill. Because of these ponderous problems, there has been a lag of positive action on health legislation.

Nearly 1,200 of the 19,000 bills in the hopper during this last session of Congress dealt with medicine. While little action has been taken because of more pressing problems before the legislators, it is almost certain that renewed interest in the next session of Congress is inevitable. How the legislators will vote on medical matters will depend largely on the activity, or inactivity, of the physician behind the scene.

Doctor Kirkley pointed out that the
(continued next page)



Carl B. Lechner, M.D., Erie, meets with Congressman Joseph P. Vigorito, Erie, in his chamber at the Longworth House office building.

(Left to right) George E. Farrar, Jr., M.D., Philadelphia, President-elect, PMS; Congressman Lawrence G. Williams, Springfield; William Y. Rial, M.D., Delaware.



(Left to right) Robert H. Craig, Jr., Executive Assistant, PMS Council on Governmental Relations; Congressman Thomas E. Morgan, M.D., Fredericktown, Dean of the Pennsylvania Delegation to Congress; W. Ralston McGee, M.D., Fayette; Eugene Zimmerman, Executive Director, PaMPAC; William A. Limberger, M.D., Chester, PMS Chairman of the Board.

(Left to right) John H. Harris, Sr., M.D., Dauphin; William A. Limberger, M.D., Chester, PMS Chairman of the Board; Congressman Herman T. Schneebeli, Williamsport.



newsfronts

Pennsylvania physicians who visit their Congressmen in Washington, who even maintain regular contact by mail or phone, will influence what happens to national legislation in medicine. However, the political activity must be aggressive and must have continuity. Once we have earned a rapport with the Washington representatives, positive results will ensue.

In a similar dialogue, Maurice Kramer, AMA lobbyist, pointed out that the AMA, because of its national level of interest, is limited in the degree of influence it can exert on Congressmen. He said that the legislators are interested, most of all, in their voter following from their home states. If the voters are content, the Congressmen will stay in office—and that is the real meat of the matter.

M.D. a Voter Leader

The physician is a voter leader with a following in his community and the politician is aware of that. However, the doctor must let his Congressman know that he is an intelligent constituent, that he is vitally interested in the political issues of the day and that he, the physician, intends to be a spokesman for these issues. Not only must the physician express his position by offering advice to his representatives, he must also place demands on them for specific legislative action—pointing out to the Congressmen why the action is beneficial both to the practice of medicine and to their own political careers.

Stand Must Be Taken Now

Authoritative spokesmen predict that the next session of Congress will take a deeper look into the affairs of the medical profession. The stimulus has been provided by the Ribicoff hearings on medical costs, by the generic drug legislation sponsored by Senator Russell Long and the nagging interference of the FDA in the drug industry, the poor peoples campaign, the activity of the Joint Economic Commission to consider guaranteed annual wages (coupled with the hows of financing medical care for the poor), and the studies and modifications to be made in comprehensive health programs (Medicare and Medicaid), among others.

It cannot be emphasized too strongly that little time remains for physicians

to declare their stands clearly on these matters so that they may continue to direct their own destinies and that of the medical profession.

During an hour-long debriefing session following the visit to Congressmen in Washington, the members of the Pennsylvania medical delegation unanimously agreed that immediate steps must be taken, both individually and through the capable offices of PaMPAC, to establish a firm, open communication line between themselves and their representatives; and that these avenues must be kept open by a vigorous and untiring program to provide legislators with up-to-the-minute reports on the sentiments and desires of their constituents. Only with such support can the Congressmen act judiciously and intelligently in favor of the medical profession.

Washington Impressed With Pa. Delegation

A few letters, a few phone calls and a few visits by a few diehard crusaders will not do the job that needs to be done. It is noteworthy to mention at this point that Pennsylvania legislators contacted were outspokenly impressed with the organization, the determination and the representation of the June Washington visit. It is obvious that the effort must be statewide, with every doctor in every congressional district rendering his share of motivation to the political force.

Because of the exceptional gains achieved from this initial visit of physicians to their representatives, the group, in conclusion, urged the request of sufficient funds so that organized trips of this nature may be repeated annually.

Representing the medical profession in the Commonwealth were: Allegheny—William A. Barrett, M.D.; M. A. Cambest, Jr., M.D.; P. J. Kyne, M.D. and D. I. Zubritzky, M.D.; Butler—Ralph M. Weaver, M.D.; Cambria—John B. Lovette, M.D., and Edward Martin, Jr., M.D.; Chester—William A. Limberger, M.D.; Delaware—William Y. Rial, M.D.; Clinton—Robert F. Beckley, M.D.; Dauphin—John H. Harris, Sr., M.D.; Erie—Carl B. Lechner, M.D.; Fayette—W. Ralston McGee, M.D.; Huntingdon—William B. West, M.D.; Lackawanna—Richard L. Huber, M.D. and Joseph A. Walsh, M.D.; Philadelphia—E. L.



William B. West, M.D., Huntingdon (left) and Congressman J. Irving Whalley, Windber.



Paul S. Friedman, M.D., Philadelphia (left), and Congressman Richard S. Schweiker, Worcester.

Clark, M.D.; George E. Farrar, Jr., M.D.; Ann Hankins Ford, M.D.; Paul S. Friedman, M.D.; and Robert S. Pressman, M.D.

Among the Congressmen receiving the Pennsylvania delegation were: Senators Joseph S. Clark and Hugh Scott of Philadelphia; Representatives William A. Barrett, Robert N. C. Nix, James A. Byrne, Joshua Eilberg and

William Green of Philadelphia; George M. Rhodes of Reading; Lawrence G. Williams of Springfield; Edward G. Biester, Jr., of Doylestown; G. Robert Watkins of West Chester; Joseph M. McDade of Scranton; Daniel J. Flood of Wilkes-Barre; J. Irving Whalley of Windber; Richard S. Schweiker of Worcester; William S. Moorhead, Robert J. Corbett, Elmer J. Holland and

James G. Fulton of Pittsburgh; Fred B. Rooney of Bethlehem; Edwin D. Eshleman of Lancaster; Herman T. Schneebeli of Williamsport; George A. Goodling of Loganville; John H. Dent of Jeannette; John P. Saylor of Johnstown; Albert W. Johnson of Smethport; Joseph P. Vigorito of Erie; Frank M. Clark of Bessemer and Thomas E. Morgan of Fredericktown.

Congressman Thomas E. Morgan, M.D. (left), Fredericktown, Dean of the Pennsylvania Delegation to Congress and Herman T. Schneebeli, Williamsport.



Robert F. Beckley, M.D. (left) Clinton, and Congressman Albert W. Johnson, Smethport.



Dr. Spaeth Wins PAOO Service Award

The Pennsylvania Academy of Ophthalmology and Otolaryngology, at its annual convention presented plaques and citations to five Pennsylvanians who have made outstanding contributions to the medical profession and to their communities.

The Distinguished Service Award was made to Edmund B. Spaeth, M.D., a Philadelphia ophthalmologist, for noteworthy service to medicine as chief of the Eye Service at Walter Reed Hospital for eight years.

William G. Piper, a member of the Pennsylvania House of Representatives, received the Academy's Citation for Distinguished Service for exceptional service to the public as chairman of the state's licensure committee.

Two Community Service Citations will be given to other laymen this year for their dedicated service to the blind and to the deaf.

Harold G. Scheie, M.D., Philadelphia was elected president of the Pennsylvania Academy of Ophthalmology and Otolaryngology at the annual convention.

He succeeds retiring president John T. Dickinson, M.D., Pittsburgh, and will serve a one-year term of office.

Elected at the meeting was H. Ford Clark, M.D., Huntingdon, Pa., who was chosen president-elect by the membership, to take office in 1969.

Other officers elected by the Academy are as follows:

First Vice President—Jay G. Linn, Jr., M.D., Pittsburgh

Second Vice President—C. Fremont Hall, M.D., Phoenixville

Third Vice President—James V. Quereau, M.D., Reading

Donaldson Awards Presented



The 1967 Walter F. Donaldson Awards for outstanding medical and health television and radio reporting are presented by John H. Harris, Sr., M.D., (center) President, PMS, to Gordon Thomas (left), accepting for WIP-Radio, Philadelphia, and Gunnar Back, accepting for WFIL-TV, Philadelphia. WIP entered the competition with a documentary on emphysema entitled "A Breath of Hope." WFIL-TV competed for the television award with their one-hour color documentary on air pollution entitled "Our Vanishing Fresh Air." Mr. Thomas produced, wrote and reported the radio entry and Mr. Back was the producer, writer and reporter of the television program. The Awards were presented during the Pennsylvania Association of Broadcasters Annual Convention in Lancaster.

Newly-elected directors to serve for three years: Joseph P. Atkins, M.D., Philadelphia; Hillard M. Himelfarb, M.D., Chambersburg and Clyde B. Lamp, Jr., M.D., Pittsburgh. Re-elected to office are: Bruce A. Grove,

M.D., York, Treasurer; Benjamin F. Souders, M.D., Reading, Editor of Transactions (the Academy's semi-annual publication) and Robert E. Shoemaker, M.D., Allentown, Secretary for Instruction.

THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA

FOUNDED 1824: A chartered university since 1838. Coeducational 1961.

FACILITIES: Jefferson Hall contains modern well-equipped laboratories, the Daniel Baugh Institute of Anatomy, and a student-faculty activities center; Jefferson Medical College Hospital; Curtis Clinic—an outpatient center; Barton Memorial Division of Chest Diseases; teaching museums and libraries; and instruction privileges in sixteen other hospitals.

ADMISSION: For full particulars regarding admission requirements write to Samuel S. Conly, Jr., M.D., Associate Dean and Director of Admissions, 1025 Walnut St., Philadelphia, Pa. 19107.

WILLIAM F. KELLOW, M.D.
Dean and Vice President

The
AMBAR
SCRAPBOOK
of

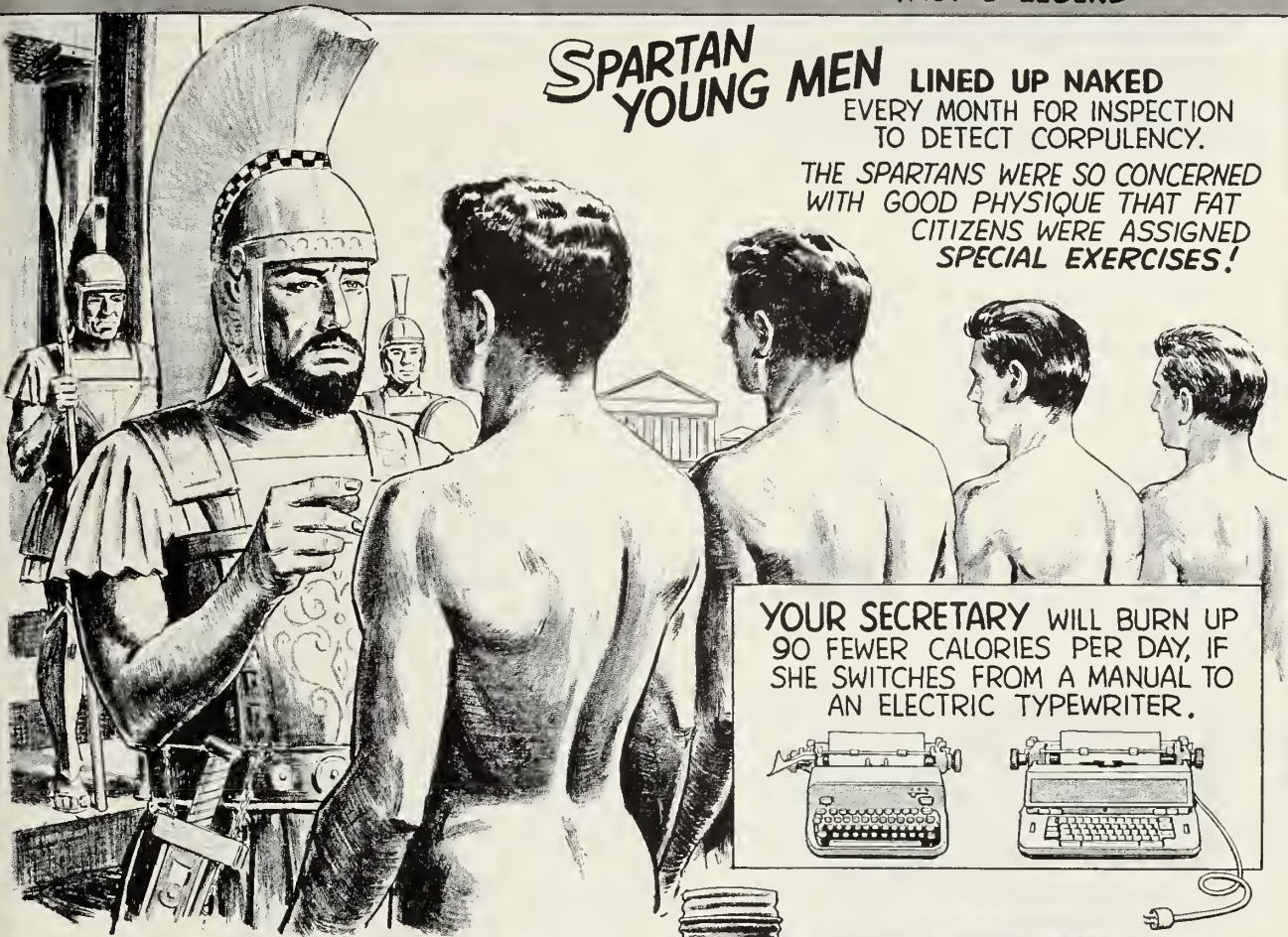
Obesity Oddities

FACT & LEGEND

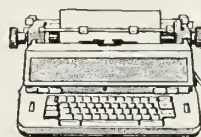
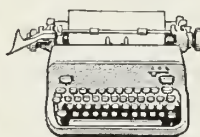
SPARTAN YOUNG MEN

LINED UP NAKED
EVERY MONTH FOR INSPECTION
TO DETECT CORPULENCY.

THE SPARTANS WERE SO CONCERNED
WITH GOOD PHYSIQUE THAT FAT
CITIZENS WERE ASSIGNED
SPECIAL EXERCISES!

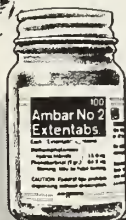


YOUR SECRETARY WILL BURN UP
90 FEWER CALORIES PER DAY, IF
SHE SWITCHES FROM A MANUAL TO
AN ELECTRIC TYPEWRITER.



DIETING IS GREATEST IN THE MONTHS:
JANUARY-FEBRUARY AND MAY-JUNE.

OVERWEIGHT PEOPLE
ARE LEAST
INTERESTED
IN DIET IN
DECEMBER.



THE Cost of
AMBAR EXTENTABS

IS APPROXIMATELY
ONE-HALF THAT OF
OTHER LEADING
APPETITE
SUPPRESSANTS.



AN IMPORTANT FACTOR
IN LONG-TERM THERAPY!

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting. Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H-ROBINS



The relief received from the first Trocinat 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinat 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.

RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

newsfronts

PAMA Officers Installed

Newly elected officers of the Pennsylvania Association of Medical Assistants were installed at the annual convention of the organization held May 17-19 at the Holiday Inn, Beaver Falls and include Sally Sigafoos, Lancaster, president; Jean F. Schindler, Pittsburgh, vice president; Geraldine Shunkwiler, Paoli, president-elect; Kathleen Ramsey, Reading, recording secretary and Lillian Sands, Erie, treasurer.

J. Everett McClenahan, M.D., Pittsburgh, immediate past president of the Pennsylvania Medical Society, was the installing officer.

Chest Disease Congress Slated; World Attendance Expected

The Tenth International Congress on Diseases of the Chest sponsored by the Council on International Affairs of the American College of Chest Physicians will be held at the Washington Hilton Hotel, Washington, D. C., October 4-8, 1968. It is anticipated that more than 2,000 physicians from throughout the world will attend.

One hundred forty-four scientific papers on all aspects of cardiovascular and pulmonary diseases will be presented. Some of the highlights are symposiums on:

Revascularization of the Myocardium

Drs. D. B. Effler, USA; C. W. Lillehei, USA; A. J. Malm, Sweden, and F. M. Sones, USA.

Cardiovascular Surgery

Drs. M. E. DeBakey, USA; C. A. Hufnagel, USA; A. Kantrowitz, USA; M. J. Levy, Israel; S. Miyamoto, Japan; B. V. Petrovsky, USSR; A. Senning, Switzerland; P. G. Uglov, USSR; and R. Zenker, Germany.

Clinical Aspects of Myocardial Infarction

Drs. R. J. Bing, USA; I. Chavez, Mexico; E. Corday, USA; H. Knipping, Germany and I. S. Wright, USA.

Emphysema and Chronic Bronchitis

Drs. Brian B. Blades, USA; W. H. Herzog, Switzerland; T. Nakamura, Japan; A. A. Sami, Egypt; W. H. Stewart, USA; and W. T. Ulmer, Germany.

Public Health Aspects of Tuberculosis

Dr. D. G. Alarcon, Mexico, Moderator

Sarcoidosis

Dr. L. E. Siltzbach, USA, Moderator

Aerospace Medicine

Dr. C. E. Berry, USA, Moderator

Air Travel and the Cardiorespiratory System

Lt. Gen. K. Pletcher, Surgeon General, U. S. Air Force, and Dr. Peter Siegel, USA Moderators

Cine-Angiographic Technics in Cardiovascular Disease

Dr. F. M. Sones, USA, Moderator

Professor Clarence Crafoord of Stockholm will be awarded the College Medal for meritorius achievement in the specialty of diseases of the chest.

The scientific program will include twelve round table luncheon discussions, medical motion pictures, 35 Fireside Conferences (informal discussions), the Second International Conference on Medical Education, scientific and technical exhibits, and the First International Physicians Art Exhibit.

For further information and registration forms, please write the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois, 60611.

Women M.D. Return Urged

Women physicians, who have dropped out of active medical practice to care for their young children or for other personal reasons, will have a unique opportunity to resume their professional careers by participating in WMC's new retraining program, Glen R. Leymaster, WMC President and Dean, announces. This program is made possible in part by a \$30,000 grant from the Josiah Macy, Jr. Foundation.

According to Dr. Leymaster, only two other medical schools in the county have or are planning similar programs. The one at Woman's Medical will begin October, 1968 or sooner, with Ethel Weinberg, M.D., assisting the Dean. A wife and mother of two young children, Dr. Weinberg is personally acquainted with the problems many women physicians face.

All doctors enrolled in the program will be given a systematic and comprehensive review of medicine plus ample opportunity for participation in clinics, accident ward and inpatient care. A special effort will be made to keep the program flexible and tailored to fit each doctor's needs. In keeping with this, students will have an option of studying six months full time or 12 months on a half-time basis.

Applications may be obtained by writing to Dr. Ethel Weinberg, Assistant to the Dean, Woman's Medical College, 3300 Henry Avenue, Philadelphia, Pa. 19129.

Family Practice Manual Offered

A 105-page manual designed to provide the general or family physician with professional help in handling the complicated business aspects of medical practice and the important community and professional relationships involved has been developed by the American Academy of General Practice.

The manual *Organization and Management of Family Practice* attempts to fill an urgent need for expert advice in an area largely neglected by medical schools and professional organizations, states Raymond M. Kahn, M.D., chairman of the AAGP Committee on Medical Economics which guided development of the manual. It is aimed at

the graduate who wishes to avoid costly errors in establishing his first practice, and the practicing physician who wants to evaluate the efficiency of his present office procedures, Dr. Kahn says.

The manual is being made available to all Academy members. It also will be made available free of charge on request to medical students, interns, residents and medical school and hospital libraries. Others interested in obtaining a copy may do so at \$1 per copy from the American Academy of General Parctice, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Temple Students Study Psychiatry

Many of the students at Temple University School of Medicine, regardless of whether they plan to be pediatricians or geriatricians, are getting exposure to the field of psychiatry.

The Temple Health Sciences Center recently received a federal grant of almost \$300,000, to be distributed over a seven-year period, to give the future doctors a touch of psychiatry.

Eventually, plans call for all medical students to get first-hand experience in the science of recognition and treatment of diseases of emotions and the mind.

Some of the money also will be used for research projects in psychiatry.

The grant from the U. S. Department of Health, Education and Welfare, will be administered by Max C. Pepernik, M.D., associate professor of psychiatry.

To fight TB- find it first!

Make tuberculin testing routine
with every physical examination.



TUBERCULIN_(Rosenthal) TINE TEST

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



830-8/6135



close-up/MD's

Frank J. Tornetta, M.D., Norristown, director of the department of anesthesiology and of the school of anesthesia at Montgomery Hospital, has returned from the Forty-second Congress of the International Anesthesia Research Society, where he presented a scientific exhibit on *Neuroleptanalgesia*.

William Likoff, M.D., a cardiologist at Philadelphia's Hahnemann Medical College and Hospital, is featured in the cover story of the May 6th issue of *Modern Medicine*. Dr. Likoff, selected by the journal's editors as their "Contemporary" for that current issue, has been at Hahnemann since 1947, and today holds the posts of professor of medicine, head of the cardiology section, and director of the Cardiovascular Institute.



DR. LIKOFF

A. Stephen Gabor, M.D., Bethlehem, and **Clarence D. Hummel, M.D.**, Easton, were honored recently by the Northampton County Medical Society for their fifty years of service to medicine.

Newly elected officers of the Pennsylvania Society of Colon and Rectal Surgery, serving for the year 1968-69, are: President, **Howard D. Trimpi, M.D.**, Allentown; President-elect, **Joseph B. Sarnier, M.D.**, Philadelphia; Vice President, **Buchard E. Winne, M.D.**, Toledo, Ohio; Secretary, **Robert A. McGregor, M.D.**, Wilmington, Dela.; Treasurer, **Valentine R. Manning, M.D.**, Philadelphia; Historian, **Peter V. Martin, M.D.**, Allentown; Executive Council Members-at-large, **Edward D. Weiss, M.D.**, Philadelphia and **Carl J. Guzzo, M.D.**, Springlake, N. J.

Francis W. Brill, M.D., Scranton, returned recently from a medical symposium in Hawaii which was sponsored by Hahnemann Medical College.

Ulysses E. Watson, M.D., Norristown, has been appointed Medical Director of Friends



DR. WATSON

Hospital. He succeeds **Theodore J. Radomski, M.D.**, who has served as Acting Medical Director since 1967. Dr. Watson, a psychiatrist, comes to his new post from

Norristown State Hospital, where he has been serving as Director of Medical Services and Director of the Follow-up Clinic.

Joseph M. Garfunkel, M.D., Lemoyne, has been selected by the American Academy of Pediatrics to evaluate the medical aspects of Head Start Medical Consultation Service in Lemoyne.

Maurice H. Alexander, M.D., Philadelphia, has been chosen a director of the American Academy of Facial Plastic and Reconstructive Surgery. The Academy is an international medical society of approximately seven hundred otolaryngologists and other specialists who perform head and neck plastic surgery.

Douglass Thompson, M.D., Pittsburgh, was a participant in the Forty-Sixth Annual Meeting of the American College Health Association last month. His topic was *Prognosis Post Infectious Mononucleosis*.

Charles P. Ashe, M.D., Natrona Heights, has been elected to fellowship in the American Academy of Pediatrics at its recent spring session in Atlanta.

Arthur F. Krieg, M.D., assistant professor of pathology and associate director of clinical pathology at the State University of New York Upstate Medical Center at Syracuse, has been appointed associate professor of pathology and director of clinical pathology laboratories at the College of Medicine and The Milton S. Hershey Medical Center of The Pennsylvania State University.

F. Peter Kohler, M.D., urologic surgeon at The Lankenau Hospital, Philadelphia, Pennsylvania, has been appointed consultant and lecturer to the National Defense Medical Center, Republic of China, Taipei, Taiwan. He left in April for an initial inspection trip and a series of lectures.

Miles O. Colwell, M.D., medical director of Aluminum Company of America since 1960 and a nationally recognized authority on industrial medicine, has been elected a vice president of Alcoa. He first became associated with Alcoa in 1952 as part-time area medical director at the company's New Kensington Works and research laboratories. He then served as area medical director, and assistant company medical director prior to becoming director.

Herbert Wayne Copelan, M.D., has been named director, division of medicine, at the Southern Division of Philadelphia's Albert Einstein Medical Center. In his new assignment, Dr. Copelan will be in charge of all clinical and administrative functions including patient care, education and research for the division of medicine at Einstein's 300-bed Southern Division.



DR. COPELAN

Merle Bundy, M.D., Pittsburgh, has been named first vice-president of the Industrial Medical Association, international association of physicians in industry. The announcement was made at the Association's 53rd annual meeting in San Francisco. Dr. Bundy is medical director of United States Steel Corporation and clinical assistant professor of occupational medicine at the University of Pittsburgh Graduate School of Public Health.

Arthur H. Keeney, M.D., Philadelphia, has been appointed to the National Motor Vehicle Safety Advisory Council.

(continued on page 14)

Orient Adventure

DEPARTING FROM:
PHILADELPHIA and PITTSBURGH
SEPTEMBER 8, 1968

VIA NORTHWEST ORIENT PRIVATE 707 JET



14 Fun Filled Days in Exotic and Colorful Japan and Hong Kong . . . No Regimentation!
Do as You Please . . . Sightsee . . . Golf . . . Shop or participate in Group Activities.

Deluxe Hotels . . . Two Gourmet meals each day . . . All Transfers . . . Five hosts in
each city . . . 100 lbs. baggage allowance.

Now—Two can travel for little more than the price of one.

ONLY \$898 COMPLETE!

DON'T MISS THIS TRIP OF A LIFETIME!

RETURN THIS COUPON NOW!

Send to: LEHIGH COUNTY MEDICAL SOCIETY
335 North 8th Street, Allentown, Pa. 18102

Enclosed is my check for \$_____ (\$100 per person) as ORIENT ADVENTURE deposit

NAME _____

ADDRESS _____

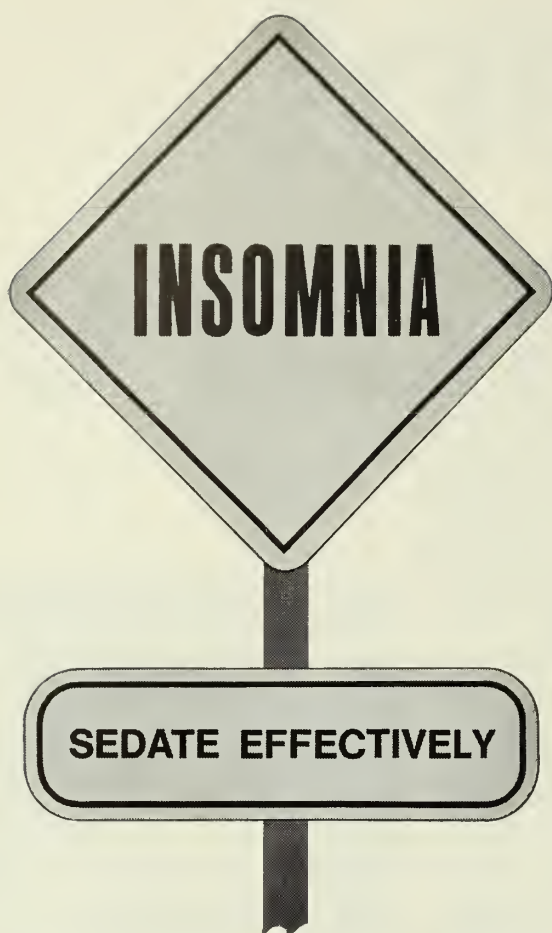
CITY _____

STATE _____

ZIP _____

PHONE _____

MAKE YOUR RESERVATIONS EARLY — SPACE STRICTLY LIMITED!



With QUI-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUI-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUI-A-ZONETM

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butobarbital, and 25 mg. phenobarbital. Bottles of 100.

Usual Adult Dose: 1 to 2 tablets before retiring.

PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.



SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201

close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society
in recent months:

ALLEGHENY COUNTY:

EDWARD F. ROONEY, M.D., 1019 Highland Bldg., Pittsburgh 15206.
JOSEPH J. SCHWERHA, M.D., 2028 Sunnysdale Road, Pittsburgh 15243.
ERNEST P. SICONOLFI, M.D., 120 Ruskin Avenue, Apt. 418, Pittsburgh 15213.
RONALD C. LENTHALL, M.D., 2545 Mossdale Blvd., Monroeville 15146.
THOMAS J. LEWIS, JR., M.D., 3985 Greenville Drive, Glenshaw 15116.
JOHN D. McMASTER, M.D., 1239 Gulf Bldg., Pittsburgh 15219.
WILLIAM A. MORRISON, M.D., 320 Holiday Drive, Pittsburgh 15237.
CLETO U. ARAYA, M.D., Braddock General Hospital, Braddock 15104.
ANTONIO J. CASTILLO, M.D., 6028 Jenkins Arcade, Pittsburgh 15222.
CIRILO T. FARINAS, M.D., 308 D Miami Street, East McKeesport 15035.

BEDFORD COUNTY:

CHARLES W. GRIFFITHS, M.D., R. D. 4, Delaney Bldg., Bedford 15522.

DELAWARE COUNTY:

BELA A. KRISTO, M.D., 5 Pilgrim Lane, Drexel Hill 19026.
LEWIS T. PATTERSON, M.D., 133 South 36th Street, Philadelphia 19104.

ERIE COUNTY:

WILLIAM T. SMITH, M.D., Department of Pathology, St. Vincent Hospital, Erie 16512.

LACKAWANNA COUNTY:

WALTER E. SEIGLE, M.D., 420 Drinker Street, Dunmore 18512.

LUZERNE COUNTY:

GEORGE P. MOSES, M.D., 69 West Union Street, Wilkes-Barre 18702.

TIOGA COUNTY:

DAVID F. GILLUM, M.D., Five Central Avenue, Wellsboro 16901.

YORK COUNTY:

CHARLES E. MacKENZIE, M.D., 819 Arlington Street, York 17403.
WILLIAM B. THORSEN, JR., M.D., Medical Arts Bldg., 912 South George Street, York 17403.
GARRY L. HOLTZMAN, M.D., 97 Shell Street, Harrisburg 17109.



capitol report

CHECKLIST OF IMPORTANT LEGISLATIVE PROPOSALS & ISSUES—PART I

INTERNAL REVENUE SERVICE—has issued regulations to tax publication advertising and exhibit income of charitable, scientific, educational, non-profit organizations like the AMA and all state medical associations. We must urge members of Congress to request the House Ways and Means Committee to call the IRS officials before it to challenge IRS authority to tax these groups for the first time in spite of the fact there has not been any new tax legislation since 1950. An amendment has been introduced to the excise tax bill, nullifying the regulations pertaining to advertising income. It passed 57-35; however, the Conferees refused to accept the Amendment with the understanding that the House Ways and Means Committee would hear the matter before adjournment this year. Ask your Representative to urge early hearings. The purpose is to put in Congress the authority for imposing tax, and not with the IRS.

CHILD HEALTH BILL—Congressman King (D-Calif) introduced HR 16616, the Child Health Act of 1968 with Senator Long (D-La) dropping into the hopper a substantially identical bill. The proposal contains three major provisions. The first calls for supplemental maternal and child welfare programs under the Maternal and Child Health Care Act to feature comprehensive maternity prenatal and postnatal care for mothers from low income families, comprehensive health care for children during their first year of life, and family planning services. The second establishes a program for determining federal payments for drugs under Medicare, Medicaid, and Maternal and Child Health Care Act programs. The third major provision gives the Secretary of HEW authority to put into effect any method of payment for health services which is developed in the "incentive reimbursement experiment" program about to be undertaken by HEW. If adopted, the provision would give the Secretary the authority, without further Congressional approval, of determining the method by which providers of care would be compensated for care which they rendered under federally assisted programs. Hearings have not been announced.

GENERIC DRUG LEGISLATION—will probably be given another college try by its chief sponsor, Senator Russell Long, and many other Senators who supported his position in 1967.

HART & NELSON HEARINGS—meant to keep the heat to the feet of the private sector of medicine and the drug companies will continue to make headlines during this important election year.



With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-gripping. Chewable. Very palatable. Economical.

EVAC-U-GEN[®]

A highly-flavored and palatable tablet of yellow phenolphthalein, sodium salicylate, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.

PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C
PRECISION
PHARMACEUTICALS

SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201



Doctor and Nurse

The original health care team was made up of doctor and nurse. This is an ancient professional coalition and its value is so clearly established that it is taken for granted in this day of so many new entrants into the field of patient care. But emphasis on its essential and permanent importance to the sick and injured may now be warranted to avoid diminishing the effectiveness of the teamwork. It is of interest to note that I have named the participants backward; it is clear that nursing is the older profession.

The winds of change are strong in our time and they have produced some difficulty in the operation of the nurse-physician relationship. So many additional health-care professionals have made their appearance and the diagnostic and therapeutic procedures have become so complex, numerous and specialized, that a simple relationship is no longer easy to maintain.

But we must make certain that the many innovations do not produce any separation or alienation of the two professions. Break-neck change does not alter the fact that the nurse and doctor share one great source of stability—our ailing fellow citizens cannot do without our united efforts. And as we improve these joint accomplishments, we do not want to give up any of the real accomplishments of our past.

Nor can we ignore the fact that many physicians have unsettled feelings in the face of difficulties in adjusting to the complexities of modern health care; some do not want to face the fact of our evolution. We must not let any nostalgia about our former relationship prevent us from facing forward to find the best way to serve our patient. The good old days cannot be recaptured.

We have a common cause but we also share many problems. The varieties of practitioners in both professions have multiplied. The advances of science have made it difficult for both nurse and doctor to keep current. Introduction of new technologies have made the boundaries of our activities uncertain. Social and economic changes have altered our roles. Levels of compensation,

methods of schooling, problems of licensure, conditions of employment and other subjects are being debated. In short, we are all studying hard to avoid being confounded.

The situation has been recognized by organized nursing and organized medicine at national and state level conferences and by other methods of intercommunication. (See page 49 of this issue for proceedings of a conference held at our State Office on March 6, 1968). More of this kind of liaison can be expected to produce much good.

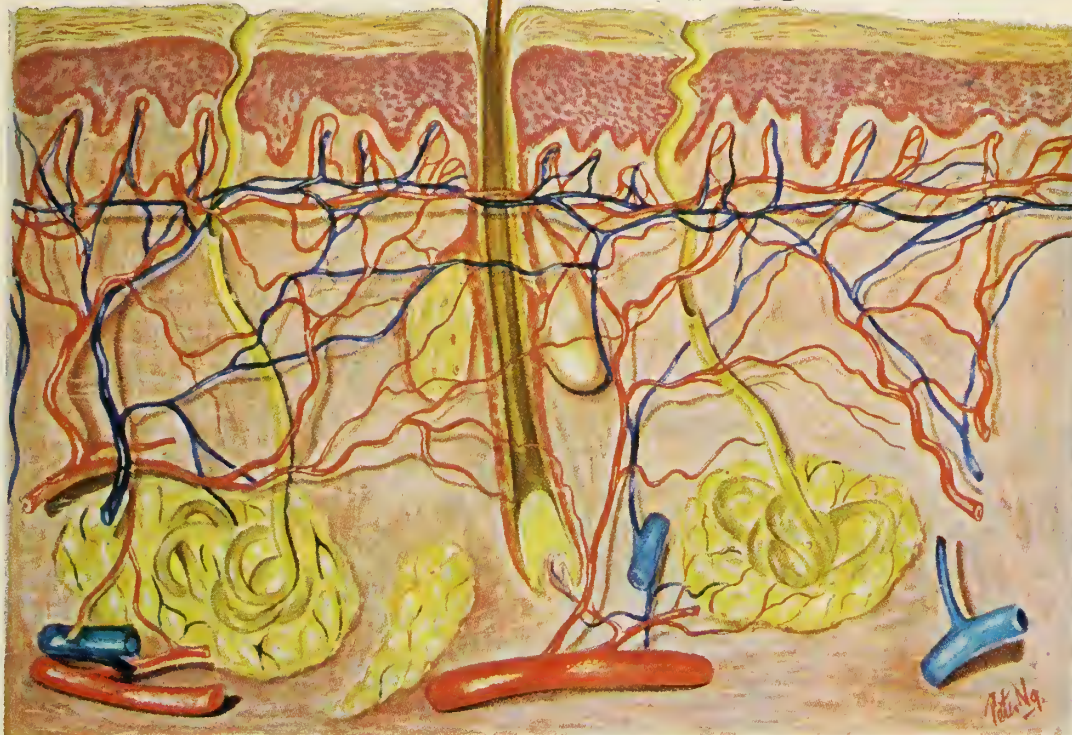
But many individual physicians are still meeting the problem by remarking that the nurse "aint what she used to be." In many cases the problem is largely semantic; the doctor thinks of the nurse as something she is not and fails to recognize the many things she has become. He has failed to notice that modern patient care has enabled the nurse to become the doctor's partner in many new activities. He fails to note that there are echelons of nurses capable of helping his patients at new levels of nursing science and technology and that many are capable of extending his care by independent activity in suitable circumstances.

I digress to point out that, as in the case of the physician, the proliferation of abilities and the diversification of skills are not done at the expense of fundamental principles. The lady with the lamp is still with us although she has added greatly to the list of things she can give the sufferer.

Every physician has a duty to do his part to strengthen the nurse-doctor axis. The fact that nurses are contributing more in every way to patient care should be recognized by all; we need all the help we can get, the more so as the job increases in size and complexity. Each of us must be aware of the problems confronting our ally the nurse, offer help where we can and seek her understanding and assistance where she can relieve our own difficulties. We must recognize our common cause and contrive a more effective service to man. Getting together will pay; failure to do so will cost dear.

CBL

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B — bacitracin — neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'[®]

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

New

Tegretol[®] carbamazepine

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

Warning

Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed. Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.

Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long as a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.

Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.

Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.

In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.

Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect. Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.

Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.

Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.

Before initiating therapy, the following laboratory procedures should be performed:

1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.

2. Baseline evaluations of liver function.

During treatment with Tegretol, the following laboratory procedures should be performed:

1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent

laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.

2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.

3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.

4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.

Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.

Dosage and Administration The drug should always be taken with meals, if possible.

Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.

Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.

At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.

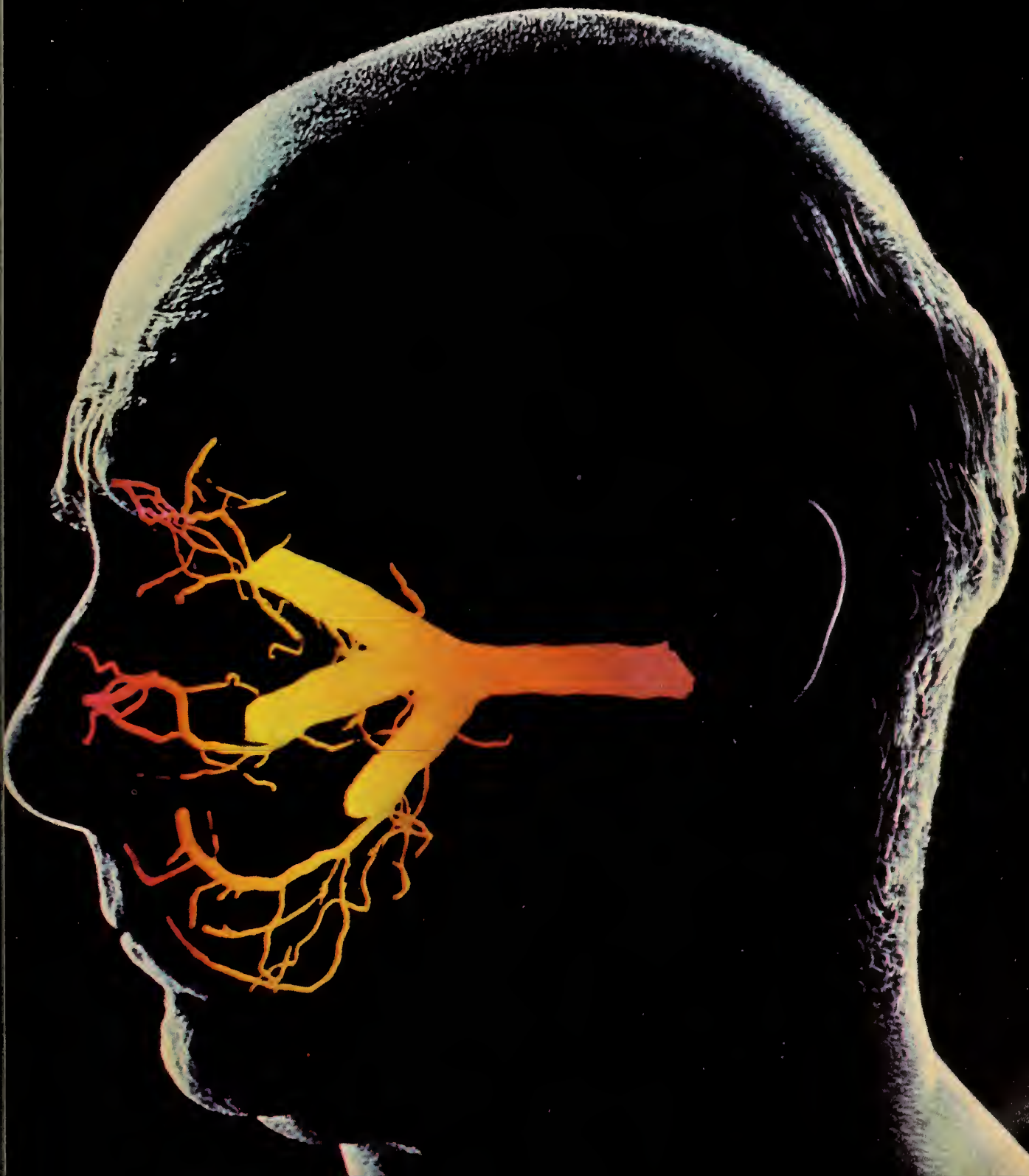
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000.

For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsey, New York 10502

Geigy

uncommon relief of
uncommon pain





A little

Just one 50 or 100 mg.
tablet in the morning can
work a long diuretic day
in edema and hypertensi



Hygroton® can work a long day too

chlorthalidone

at's because of its prolonged
tion, usually providing smooth
cretic activity throughout the day.
d one-a-day dosage, in the
ng run, means few tablets to take
d few tablets to pay for.

Hygroton, brand of chlorthalidone,
may mean troublesome side effects
for certain patients. And you can't
prescribe it in cases of demonstrated
hypersensitivity to the drug or in
severe renal or hepatic diseases.

Before writing it for your
patients, please check the
Prescribing Information.
It's summarized on the
next page.

Hygroton
chlorthalidone in edema and hypertension

Geigy



in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always

be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness,

weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)R2-46-230-D

For full details, please see the complete prescribing information.

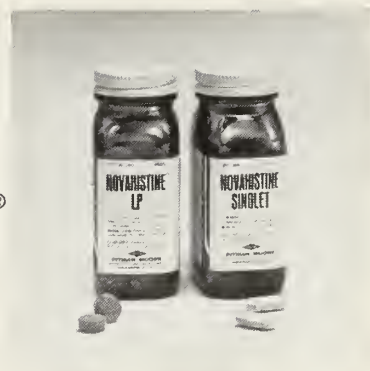


Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg. Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets, you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient. Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention.

Caution ambulatory patients that drowsiness may result.



PITMAN-MOORE Division of The Dow Chemical Company,
Indianapolis



"Nothing else I've tried seems to work, so I decided to give you a crack at it."

MeadJohnson—pharmaceuticals created for your specialized clinical needs



She relies
on your
contraceptive
advice

She can expect to continue Oracon for years

ORACON

16 White—Ethinyl Estradiol, 0.1 mg. Tablets, 5 Pink—Dimethyl-sterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control

program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period.

Detectable amounts of the active ingredients in oral

contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some

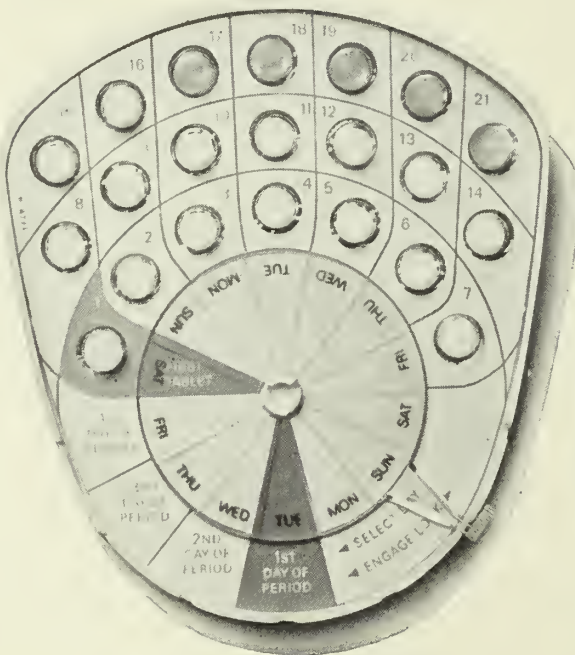
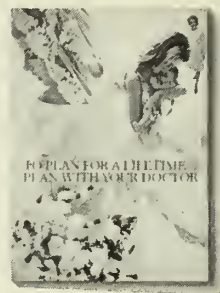
physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.

The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.



in the Pakette® dispenser

ORACON®

16 White—Ethinyl Estradiol, 0.1 mg. Tablets, 5 Pink—Dimethisterone 25 mg. and Ethinyl Estradiol, 0.1 mg. Tablets

Mead Johnson
LABORATORIES



Cardiovascular Surgery—1968

Part II

What, in your opinion, have been the most significant factors contributing to the development of cardiac surgery?

Primarily, the presumption on the part of a very small number of physicians that surgical manipulation within the heart could be carried out without enormous risk has led to successful performances of mitral commissurotomy for stenotic lesions. This feat eliminated centuries of fearful speculation and generated a progressive and fruitful advance on the ever-widening targets of intra-cardiac surgery. This, of course, would have been severely limited except for the development of the so-called "heart-lung" machine, which lessened the burden on surgical skills and enlisted the participation of enthusiastic surgeons, cardiologists, physiologists and chemists on a world-wide scale. Growing simultaneously with these explosive developments was the emergence of the largely nameless cardiac hemodynamics specialist who developed the techniques and instruments of cardiac catheterization with its sharp regional x-ray visualization and microsensors which now permit the precise anatomical, physiological and biological diagnoses, so necessary for a superior surgical result.

How do you think these future cardiac teams will be organized?

It is likely that the present government-sponsored regional health plans will dictate that the university oriented medical centers be encouraged to undertake research, to disseminate and exploit break-throughs in the emerging knowledge and techniques, and to require the establishment of comprehensive work teams for the purpose of performing practical heart surgery.

Will this scheme require enormous financial expenditures?

Yes, it will. However, I believe it will be justified on the basis of the rewards registered in terms of recovered productivity and propagation of health.

Will this mean that the community hospitals will not treat heart patients?

The primary business of a community hospital is to treat all incoming patients completely, in so far as it is able. Only rarely is a community hospital able to secure the equipment and skilled man power necessary to carry out heart surgery. Thus, for very practical reasons, most hospitals will provide the treatment for the majority of heart patients and will refer only the problem patients to the nearest adequately equipped medical center.

Will this plan bring about an entirely different doctor-patient relationship?

No. The patient still retains his personal physician, and the relationship will be enhanced when the patient realizes that he is being referred for valid reasons to the temporary care of a skilled specialist. He will understand the necessity of in-depth evaluation which may require cardiac catheterization, angiography, tissue and fluid determinations and cardio-pulmonary physiological studies. He will, at once, appreciate the necessity for a complex and efficient "cardiac team" that revolves around him and will understand that it has been designed for his protection.

Is such a "cardiac team" difficult to initiate?

No. Such a system is already operative in a semi-formal way. By ne-

cessity, development began from a nucleus of especially interested subspecialists in allied disciplines, who were mutually attracted into units now known as "cardiac teams." Their sole purpose is to advance the science of heart surgery. The hard core of each team is made up of clinical cardiologists, thoracic surgeons, cardiac physiologists and hematologists. In turn, they receive support from the pathologists, microbiologists, physicists, chemists, and non-medical engineers. These teams serve to stimulate research, dictate direction of efforts and test the enduring validity of each new adventure in their common quest. Once organized, they offer their services to the community at large, whose medical population, through an increased awareness and deepened knowledge, will, in turn, refer their problem patients for team consideration and action. No individual physician should undertake the entire burden of total cardiac care in his problem patients as long as such centers are reasonably close to his area. An ever-widening avenue of communication between the community practicing physician and the local cardiac center is certain to evolve, and its robust reality will weld together the forces of all in a common effort to eliminate heart disease.

■ William G. Leaman, Jr., M.D., questions Thomas J. E. O'Neill, M.D., Associate Professor of Thoracic Surgery and Head of the Section, Woman's Medical College of Pennsylvania, Philadelphia, Pennsylvania.

■ William G. Leaman, Jr., M.D., Fellow, Council on Clinical Cardiology of the American Heart Association, edited this Brief for the Council on Scientific Advancement, in cooperation with the Pennsylvania Heart Association.

An anorectic will help her lose weight—
but can she keep it off?
You need more than a pill
(even ours) to do that!



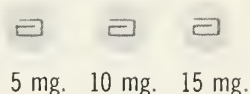
That's why Abbott offers you a pill plus a program.



The Product

*For smooth appetite
control plus mood
elevation*

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



*For patients who can't
take plain amphetamine*

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL® 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



801444

*Please see Brief Summary
on next page.*

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

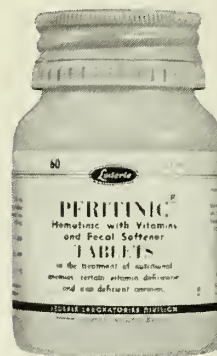
Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

anticoptive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60



anticoptive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)



LEDERLE LABORATORIES

A Division of American Cyanamid Company
Pearl River, New York 10965

488-7-6062

THE SIXTH NATIONAL CANCER CONFERENCE

DENVER HILTON HOTEL
DENVER, COLORADO
SEPTEMBER 18-20, 1968

SPONSORS: AMERICAN CANCER SOCIETY, INC.
AND THE NATIONAL CANCER INSTITUTE

NATIONAL CANCER CONFERENCES ARE HELD EVERY FOUR
YEARS AND CONSTITUTE A SUMMARIZATION OF RECENT
DEVELOPMENTS IN RESEARCH AND CLINICAL CANCER.

Plenary Sessions

September 18 ■ THE BIOLOGY OF CANCER AND THE
CANCER CELL

■ BASIC PROBLEMS AND ADVANCES IN
CANCER SURGERY

September 19 ■ TEN CITY CANCER SURVEY

■ VIRUSES AND CANCER

■ THE BIOCHEMISTRY OF CELL AND
VIRUS MULTIPLICATIONS

■ BASIC PROBLEMS AND ADVANCES IN
RADIATION THERAPY

September 20 ■ CARCINOGENIC NATURAL PRODUCTS

■ BASIC PROBLEMS AND ADVANCES IN
CANCER CHEMOTHERAPY AND HOR-
MONE THERAPY

Simultaneous Site Panels

EVALUATING DIAGNOSTIC AND THERAPEUTIC TECHNIQUES

September 18 Genitourinary Cancer ■ Breast Cancer ■
Lymphoma and Leukemia

September 19 Cancer of the G. I. Tract ■ Skin Cancer ■
Female Pelvic Cancer

September 20 Head and Neck Cancer ■ Lung Cancer ■
Skeletal and Soft Part Tumors

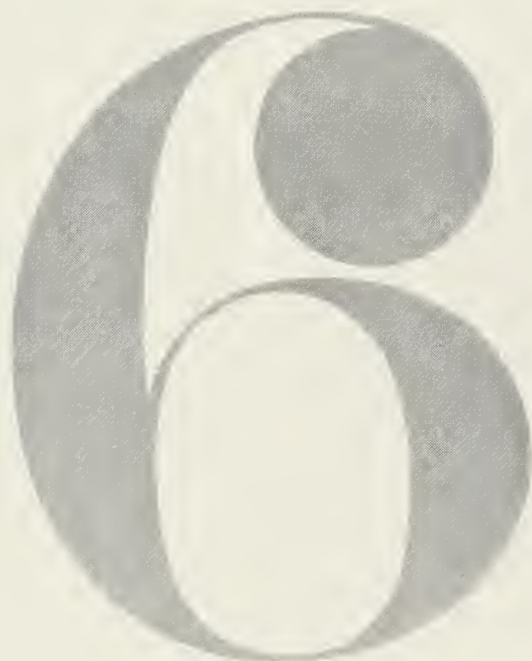
**SESSIONS ARE OPEN
TO CANCER RESEARCH PERSONNEL,
THE MEDICAL PROFESSION
AND STUDENTS.**

Programs, advance registration cards and hotel reservation
forms may be obtained from Divisions of the American
Cancer Society or from the Coordinator, Sixth National
Cancer Conference, 219 E. 42nd St., New York, N. Y. 10017.

PLEASE REGISTER IN ADVANCE

NO REGISTRATION FEE

PENNSYLVANIA CANCER FORUM PAGE—pre-
sented cooperatively by the Council on Scientific Ad-
vancement of the Pennsylvania Medical Society, the
Pennsylvania and Philadelphia Division of the Ameri-
can Cancer Society, and the Cancer Control Section,
Pennsylvania Department of Health.





Tofrânîl®, imipramine hydrochloride

Indications: Tofrânîl is recommended for the treatment of depressive states of diverse psychopathology.

Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.

Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician,

the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.

Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure. In rare instances, transient cardiac arrhythmias have occurred in hyper-

thyroid patients and in patients receiving thyroid medication when this compound was added to the regimen.

Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.

The drug is not recommended at the present time in patients under 12 years of age.

Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episode) which may require dosage reduction.

Magna
cum
depression

ed/or addition of a tranquilizer or
temporary discontinuation of the drug,
leptiform seizures, orthostatic
hypotension and substantial blood
pressure fall in hypertensive patients,
purpura, transient jaundice, bone mar-
row depression including agranulocy-
tosis, sensitization and skin rash
including photosensitization, eosino-
philia, and mild withdrawal symptoms
on sudden discontinuation after pro-
longed treatment with high doses.
Occasional hormonal effects (im-
potence, decreased libido, and estro-
genic effects) may be observed.
Opine-like effects may be more
pronounced (e.g. paralytic ileus) in
susceptible patients and in those
receiving anticholinergic agents (includ-
ing antiparkinsonism drugs).
Adult Dosage: Initially,
75 mg. daily, increased, if necessary,
to 50 or 200 mg. Maintenance dosage
may be lower, 50 to 150 mg. daily, if
possible.

Geriatric and Adolescent Dosage:
Initially, 30 or 40 mg. daily, which may
be increased according to response
and tolerance. It is usually unneces-
sary to exceed 100 mg. daily.
A lag in therapeutic response, lasting
from a few days to a few weeks,
should be expected. When dosage
recommendations are already being
followed, increasing the dosage does
not normally shorten this latency
period and may increase the inci-
dence of adverse reactions.
Availability: Round tablets of 25 and
50 mg.; triangular tablets of 10 mg.
for geriatric and adolescent use; and
ampuls, each containing 25 mg. in
2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to
the full Prescribing Information.

For him, commencement.

For his mother, the beginning
of his career may seem the end
of hers. The end of feeling
needed and useful. The begin-
ning, perhaps, of a pathological
depression.

Tofrānil can often relieve the
symptoms of her depression. If
it can relieve her mental anguish,
you may be able to help her
graduate into a new and fruitful
life of her own.

Tofrānil could be her commence-
ment, too.

Tofrānil® Geigy imipramine hydrochloride in depression

The use of Tofrānil in patients receiving
M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease,
hyperthyroidism or increased intraocular
pressure; in those receiving anticholinergics
(including antiparkinsonism agents), thyroid
medication or adrenergic neuron-blocking
antihypertensive agents; and in those in the
first trimester of pregnancy, the precautions
discussed in the Prescribing Information
should be carefully observed. Although toxic
reactions severe enough to require discontinua-
tion of Tofrānil are uncommon, please refer
to the Prescribing Information for a description
of such instances when discontinuation may
be necessary.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



***"Everything looks fine,
but we should do something about that extra weight you're putting on."***

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain*.

When a new dietary pattern must be established, consider the adjunctive use of **BAMADEX SEQUELS**. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, **BAMADEX SEQUELS** controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients

with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex[®] Sequels[®]

Dextro-Amphetamine Sulfate (15 mg.) Sustained Release Capsules
with Meprobamate (300 mg.)



LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

391-8

13th Annual
PMGA
Tournament and Dinner
September 30, 1968
**OAKMONT
COUNTRY CLUB**
*Site of the 1969 National
Amateur Golf Tournament*

- OPEN TO ALL PMGA MEMBERS
- NON-MEMBERS ADD \$3.00 ONE
TIME PMGA MEMBERSHIP FEE
- 148 GOLFER LIMIT — FIRST
COME, FIRST SERVED

PRIZES!

\$30 Entry Fee
Fee Deadline—August 15, 1968

ENTRY FORM

Name

Address

..... Zip

Certified Handicap

Other members of Foursome (Full Name)

1.

2.

3.

Lunch at Club: Yes No

Preferred Tee-off Time a.m. p.m.

Reserve Cart (Circle Choice)

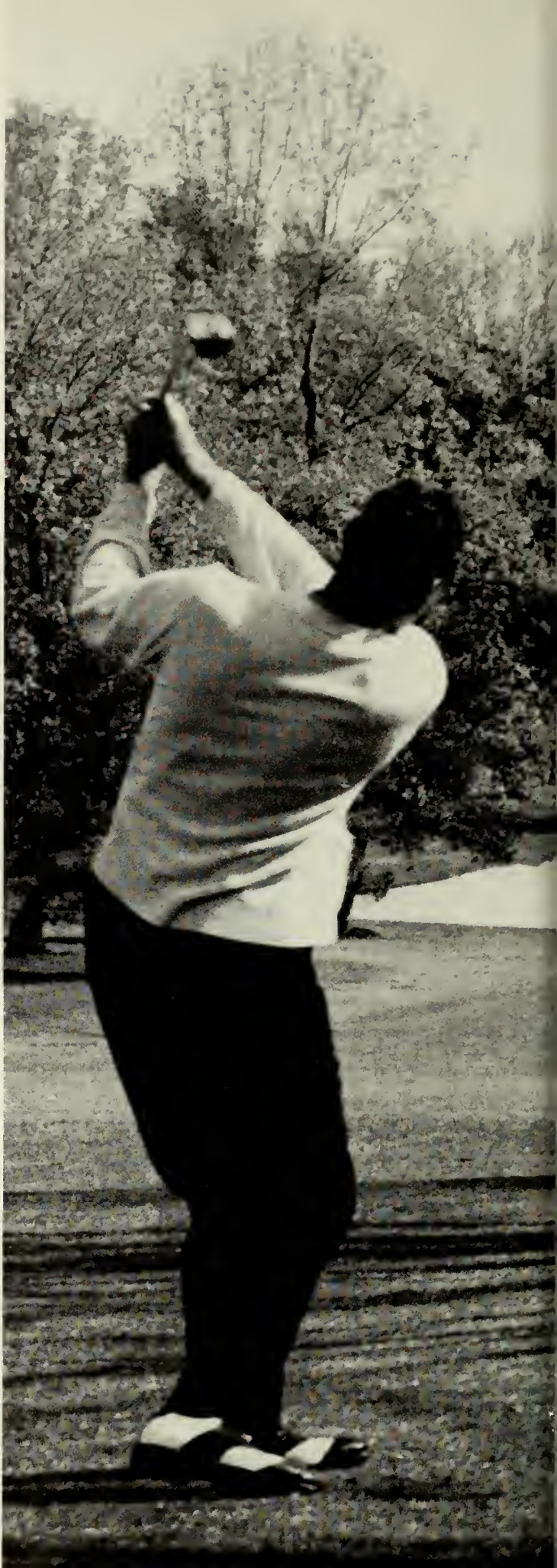
Caddies also available

(No) (One) (Two)

Make check payable (\$30.00) to:

Penna. Medical Golfing Association
Taylor Bypass and Erford Road
Lemoyne, Penna. 17043

No fee refund after September 1, 1968



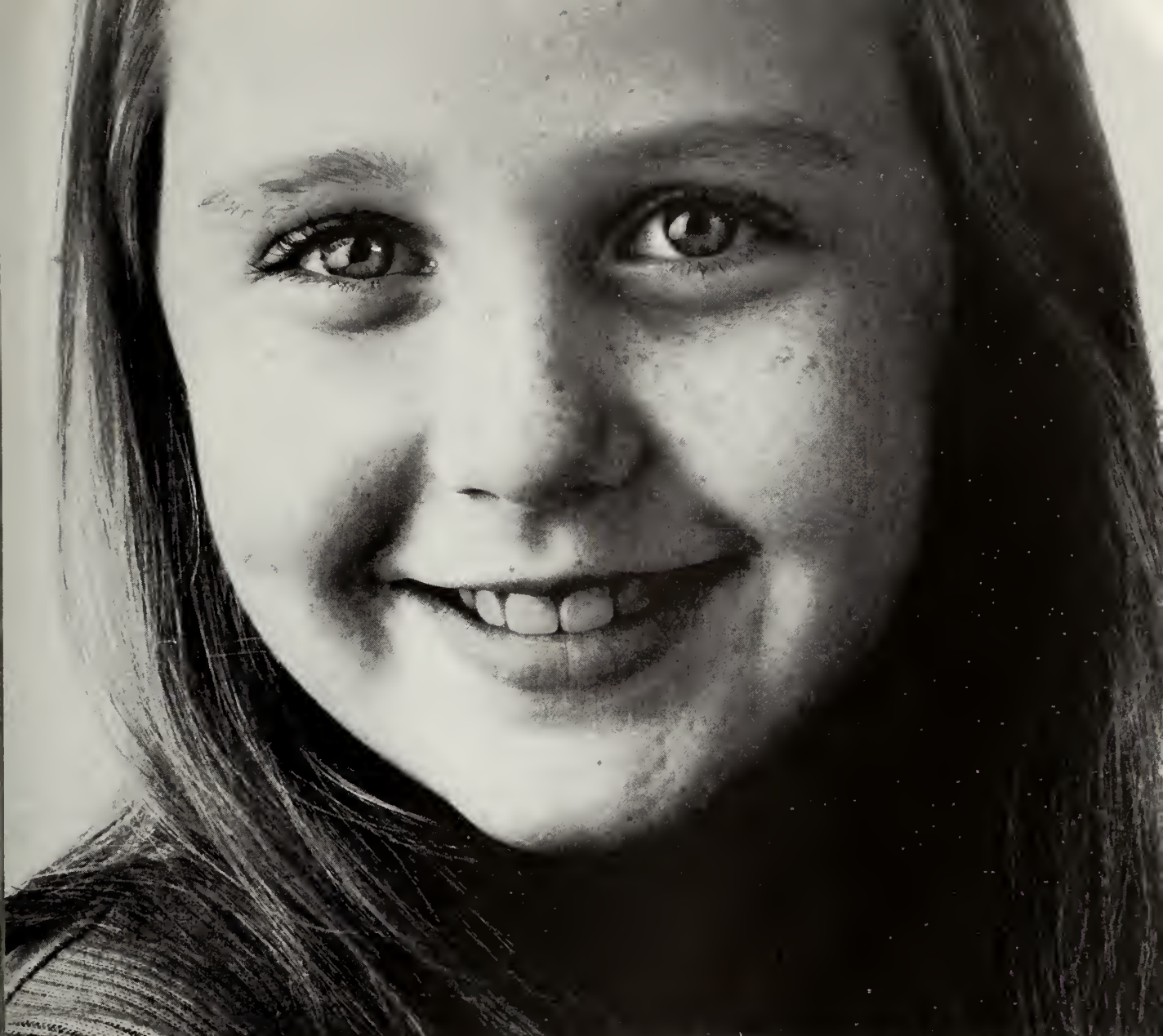


Photo professionally posed.

No injection after all! This penicillin produces high, fast levels—orally.

Pen·Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G; prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN·VEE® K
(potassium phenoxymethyl penicillin)



Open-eyed nights



Too tense to sleep...too tired to get up. Early to bed, late to rise, and not

much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is



generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anti-convulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and

protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).



Roche®
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

Valium® (diazepam)

*useful for the relief of psychic tension,
alone or with associated depressive symptoms*



DORSEY

vol. 3, no. 2

Season

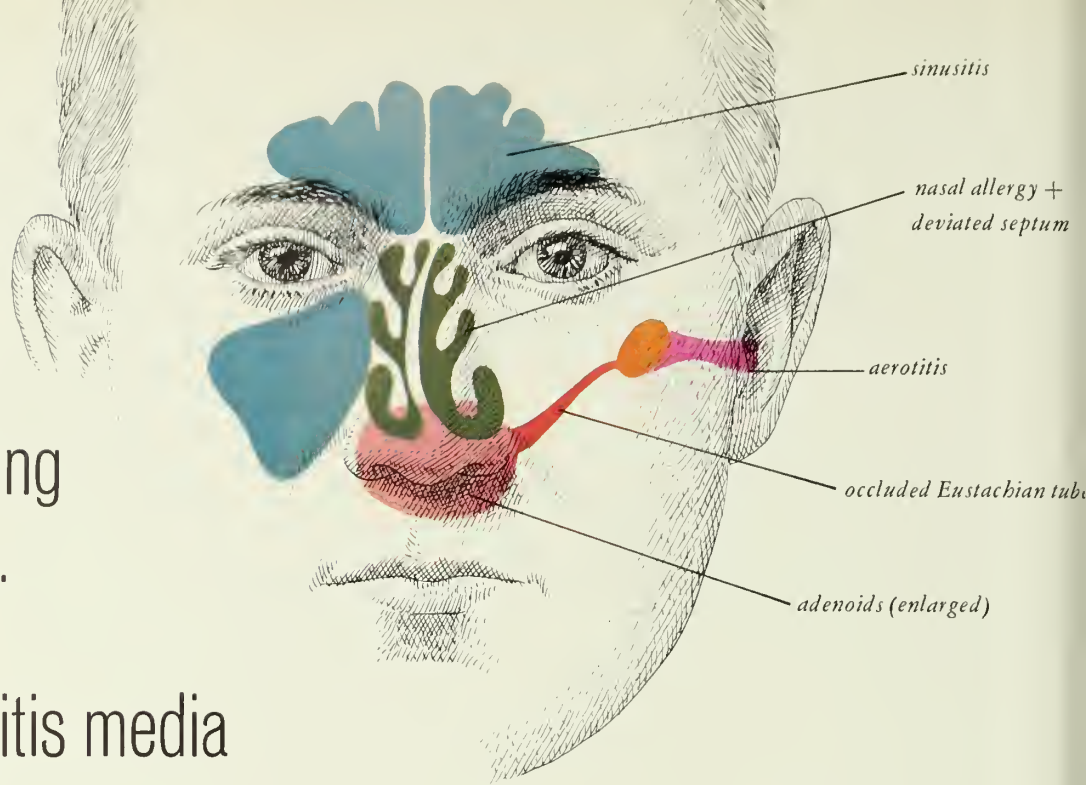
A journal within a journal published periodically in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.

this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.

the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.

Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts



Serous otitis media is probably the most common ear problem in children, especially in the winter-time. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a

false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several

times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

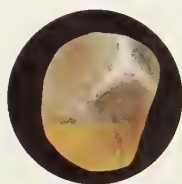
The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

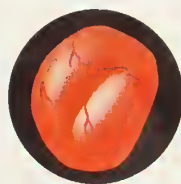
Otoscopic Views



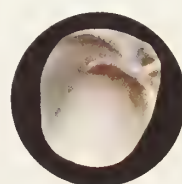
Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

References

1. Senturia, B. H. et al.; Middle Ear Effusions: Pathologic Changes of the Mucoperiosteum in the Experimental Animal, *Ann. Otol.* 71:632-648, 1962.
2. Grahne, B.; Serous Otitis Media, *Acta Otolaryng.* 58:1-8, 1964.
3. Sade, J.; Pathology and Pathogenesis of Serous Otitis Media, *Arch. Otolaryng.* 84:297-305, 1966.
4. Buckingham, R. A. and Ferrer, J. L.; Reversibility of Chronic Adhesive Otitis Media with Polyethylene Tubes, *Laryngoscope* 76:993-1014, 1966.
5. Chalot, N. I. and Lounsbury, E.; A Hearing Phenomenon and Serous Otitis, *Laryngoscope* 76:983-992, 1966.
6. Shucknecht, H. F.; Chronic Otitis Media in Children: A New Treatment, *Clin. Pediat.* 3:718-727, 1964.
7. Feuerstein, S. S.; Surgery in Serous Otitis Media, *Laryngoscope* 76:686-708, 1966.
8. Kapur, Y. P.; Serous Otitis Media in Children, *Arch. Otolaryng.* 79:38-48, 1964.
9. Silverstein, H., Miller, G. F., Jr. and Lindemman, R. C.; Eustachian Tube Dysfunction as a Cause for Chronic Secretory Otitis in Children, *Laryngoscope* 76:259-273, 1966.



You can relieve his
congestion and sniffles
and her concern
with

"The Orange Medicine"

You know it as Triaminic Syrup, but mothers of kids with colds and allergies know it as the orange-colored, good-tasting medicine that makes life a lot more livable at either end of the teaspoon. Triaminic Syrup contains not one, but two antihistamines, plus an effective oral nasal decongestant. This balanced formulation has promptly and effectively relieved nasal congestion for so many.

TRIAMINIC® SYRUP

Each teaspoonful (5 ml.) contains: phenylpropanolamine hydrochloride 12.5 mg.; pheniramine maleate 6.25 mg.; pyrilamine maleate 6.25 mg. Side effects: Drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis. Dosage: Children 1-6, ½ tsp.; Children 6-12, 1 tsp.; Adults, 2 tsp. Administer every 4 hours. Supplied: Bottles of 4 fl. oz., pints.

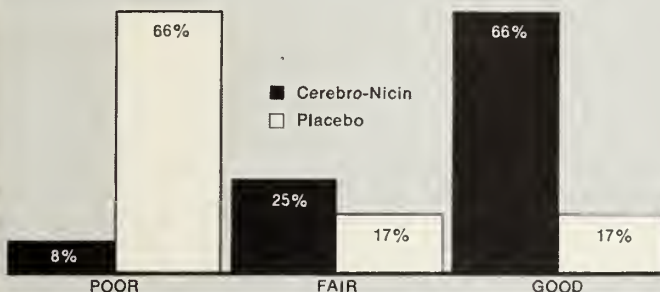
(Advertisement)

For the treatment of the aging patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin® capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylentetrazole.....	100 mg.
Nicotinic Acid.....	100 mg.
Ascorbic Acid.....	100 mg.
Thiamine HCL.....	25 mg.
1-Glutamic Acid.....	50 mg.
Niacinamide.....	5 mg.
Riboflavin.....	2 mg.
Pyridoxine.....	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylentetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.



Write for literature and samples...

BROWN

THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

Write for Product Catalog

in the treatment of
IMPOTENCE



Android®
(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID

GOOD TO EXCELLENT 75%

PLACEBO

20%

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista; Clinical Medicine, April 1966.

CONTRAINDICATIONS - Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths
Android

Android-HP
HIGH POTENCY

Android-X
EXTRA HIGH POTENCY

Android-Plus

Each yellow tablet contains:

Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . . 10 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1000.

Each red tablet contains:

Methyl Testosterone . . . 5.0 mg.
Thyroid Ext. (1/2 gr.) . . . 30 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1000.

Each orange tablet contains:

Methyl Testosterone . . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 or 2 tablets daily.

Available:

Bottles of 60, 500.

Each white tablet contains:

Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/4 gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . . . 250 mg.
Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate . . . 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.

Dose: 2 tablet twice daily.

Available: Bottles of 60, 500.

Write for literature and samples:

BROWN

THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057



also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone 2.5 mg.
Ethynyl Estradiol 0.02 mg.
Thyroid Ext. (1/6 gr.) 10 mg.
Thiamine Hydrochloride 10 mg.
Glutamic Acid 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen - only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRAINDICATIONS:** See Android. Ethynyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Do you have patients who try to hide frustration behind conformity?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you.

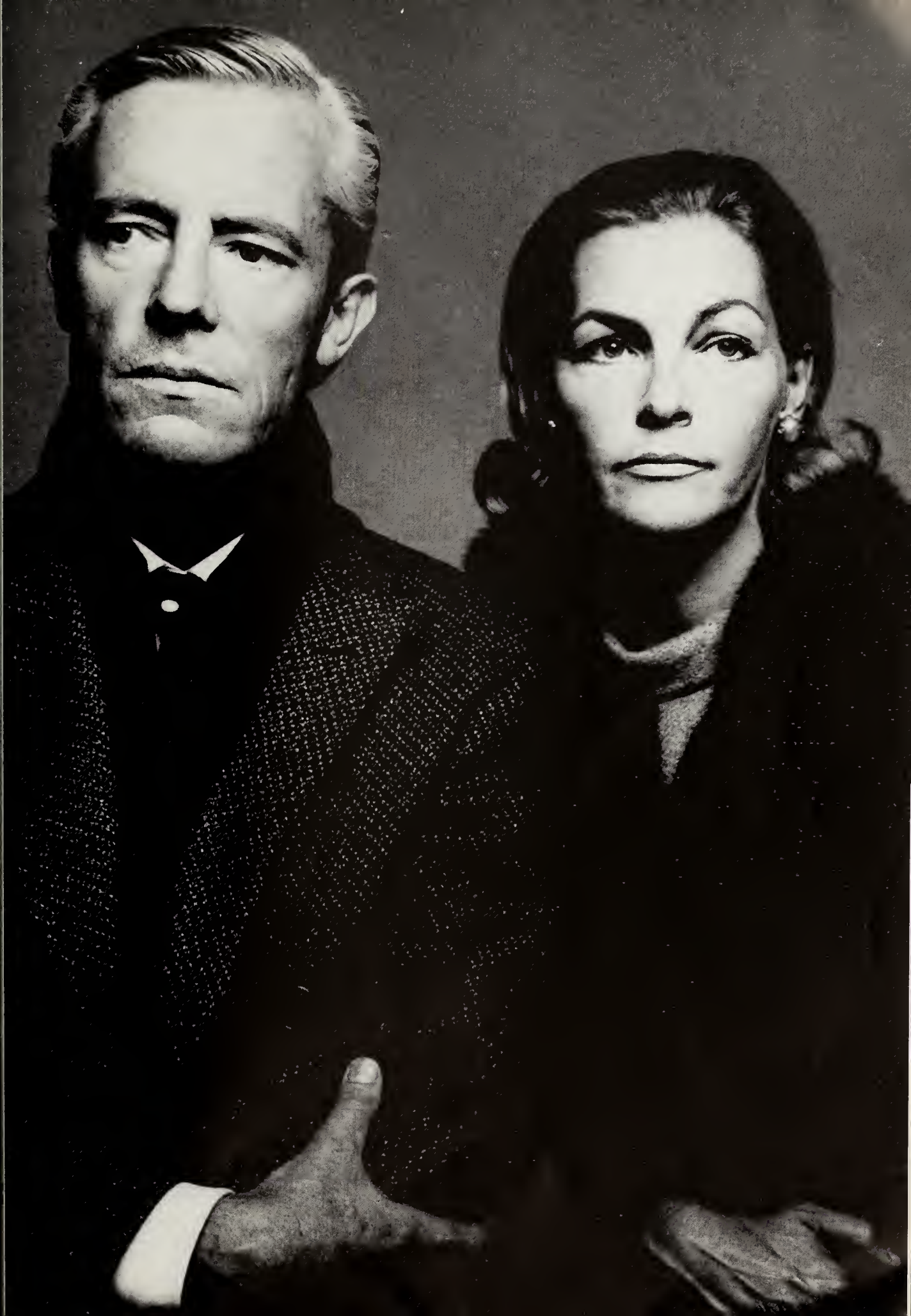
Whether depression is open or secretive, Aventyl HCl assists in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.



Eli Lilly and Company
Indianapolis, Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline Hydrochloride



At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl® HCl (nortriptyline hydrochloride, Lilly) under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl

HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl® HCl (nortriptyline hydrochloride, Lilly) is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily

10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily

10 mg.—Ages three to six, 1 Pulvule one to three times daily

Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily

Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

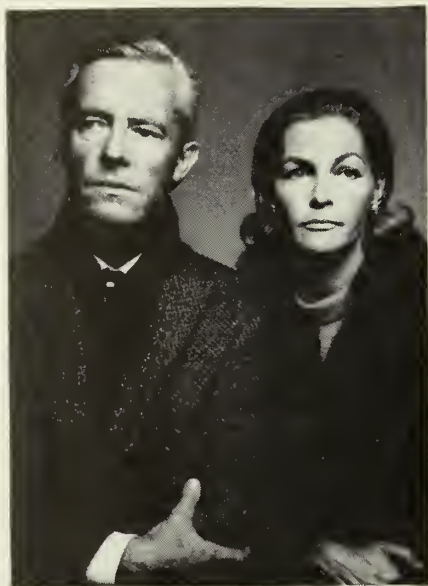
How Supplied: Liquid, 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500. [101267]

Additional information available to physicians upon request.



Eli Lilly and Company
Indianapolis, Indiana 46206



Aventyl® HCl

Nortriptyline Hydrochloride

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two months after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

*Easy on
the Budget...*

*Easy on
the Mother*

*NN Tablets & Elixir
For Iron Deficiency Anemia*



BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS
Fergon[®]
brand of FERROUS GLUCONATE



Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

EASTERN PENNSYLVANIA OFFICE:

E. L. Edwards, D. R. Lowe, L. R. Wilson, Jr., and S. B. Elston, Jr., Representatives
Suite 126-BC, The Benson, Jenkintown 19046

Telephone: 215-887-6335

WESTERN PENNSYLVANIA OFFICE: N. Wells and S. T. Ingrom, Representatives
1074 Greentree Road, Pittsburgh 15220

Telephone: 412-531-4226

Part of
the fine art
of medicine

DARVON[®]
COMPOUND-65

Each Pulvule[®] contains 65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to
physicians upon request.
ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA 46206



800118



PATIENT NEEDS IN PENNSYLVANIA

The first step toward resolving differences in the approach to better patient care was taken recently when nearly fifty nurses and physicians from throughout the Commonwealth held an historic meeting at Pennsylvania Medical Society headquarters.

Major speakers before the physician/nurse gathering were Malcolm W. Miller, M.D., Chairman, PMS Committee on Relationships with Allied Professions; Lucie S. Young, Ph.D., President, Pennsylvania Nurses Association, Charles L. Leedham, M.D., Chairman, AMA Committee on Nursing and Dorothy J. Novello, Ph.D., President—Pennsylvania League for Nursing.

Following are excerpts from their addresses outlining the subjects of: **The Needs of the Patient As Seen by the Physician, The Needs of the Patient As Seen by the Nurse, The AMA Position and Workshop Reports.**

NEEDS OF THE PATIENT AS SEEN BY THE PHYSICIAN

MALCOLM W. MILLER, M.D.

This is the first statewide conference of Pennsylvania nurses and physicians to discuss patient needs within our Commonwealth. Let us hope, and predict, that this meeting will represent the first giant step of a steadily progressive march towards improved patient care within our borders. And further let us hope that our numbers will be augmented gradually and steadily by representatives of those other groups whose members are essential to the organization and adequate functioning of an efficient and comprehensive health care team.

My assignment is listed as *The Needs of the Patient as Seen by the Physician*. I would like to take the liberty of revising the topic by changing one word so that it will read: *The Needs of the Patient as Seen by His Physician*. In other words, to emphasize a personal regard for the patient as a total being, rather than a disease entity and to further emphasize our attempt to visualize not only his technological and physiological needs but also his emotional, sociologic and economic requirements.

This is a very large order which, if covered in detail, might well oc-

cupy more than the time of today's meeting. We shall be brief, therefore, and attempt to delineate those major patient problems which nurses and physicians encounter together and then consider in few words possible means of approaching their solution.

If someone were to ask me, "What are the needs of a deep sea diver?" I would probably say, "I don't know, why not ask a diver?" Feeling that we must first consider a patient's needs as he sees them and then to visualize them from the medical viewpoint and with the benefit of his views, I selected eight of my own recently hospitalized patients. Each was requested to comment frankly, favorably or unfavorably, concerning his hospital experience and how his needs were met by physicians, nurses or other members of the care team.

A major comment here dealt with the fact that everyone seemed too busy to acquaint the patient with the essence of his medical problems, their significance, what was being done and why, and the probable outcome. This is the old story of communication and it is up to each of us individually, and primarily the physician, to sit

down and communicate with the patient.

In addition, I reviewed two more formal discussions of patient needs presented at our third national conference in Coronado, California, last February. The first was by Mr. Lloyd B. Westcott,¹ an interested and closely associated layman who has had considerable experience in the role of patient. The second was by a physician, Samuel P. Martin, M.D.² On their comments I lean heavily.

Of course, I also sat down and asked myself a few searching questions concerning my encounters with needs of my own patients. We shall consider therefore those patient needs recognized and voiced most frequently by this varied group.

Above all, the patient needs confidence that he is receiving the best possible care and that the care team is interested in him personally. This feeling came from everyone who commented. Mr. Westcott has said, "I know that when I near the end, if I feel that everyone has done his best to save me, I will go quietly—reluctantly, but quietly. If, however, I feel that someone has been negligent, or incompetent, or simply lazy, I will be frightened and dismayed and furious, and dying will seem bitter indeed."

Such confidence can be given only by the physicians, nurses and paramedical personnel caring for the patient—and by no one else.

Things that tend to shake such confidence are the endless articles and comments by books, magazines, newspapers and other communications media that attack hospitals, physicians, nurses and medical schools. The patient's confidence is shaken even more by any gesture, grimace or comment that might possibly indicate that physicians or nurses in any way doubt the wisdom of one another's decisions. We all know that medicine is not an exact science and that there is nearly always room for some difference of opinion as to diagnosis or management. However, these opinions can be expressed other than in the patient's presence and to him there should be presented always a united front.

The next major need of the patient is someone to care for him. The so-called population explosion has far outstripped numerically the available physician, nursing and paramedical manpower. Every effort must be made

to encourage and recruit students, and to extend training facilities as well as to provide the more readily procurable adequate numbers of beds, laboratories and procedural equipment. There must be more effective use of available manpower and facilities. Nurses and physicians should be able to, and should, devote their time and skills to the work for which they were specifically trained. Routine procedures, not requiring trained judgment decisions, should be carried on by less skilled personnel. When possible, diagnostic procedures and therapy should be on an ambulatory basis, releasing more hospital beds for care of the increasing numbers of non-ambulant patients. This, of course, involves, among other factors, the encouragement of third party coverage to include ambulant diagnostic and medical therapeutic procedures in their contractual agreements.

Our patient needs a care system which is immediately available when needed. There must be no psychological, social or physical barriers. Actually, few patients find care unavailable. With modern transportation, distance alone is losing its importance as a barrier to medical care. However, there must be a proper balance between taking the care to the patient and taking the patient to the care. Psychological factors leading to over or under utilization of physicians should be combated not by the creation of barriers but by a positive program of investigation and treatment.

The past has often permitted a shady aura of mysticism to surround all phases of medicine. The physician, nurse and co-workers have been in essence a closed circle imparting little or no factual or basic information to the laity. To be sure this has changed considerably in the past generation. However, it needs to change more and rapidly. The patient needs continuing health education, whether he is relatively well or whether some crisis of illness has implanted the stimulus of fear causing him to call for immediate help. There are many facets to this health instruction program. These include understandable instruction in diet, personal and public hygiene, preventive medicine, immunization, the proper and improper use of drugs, of tobacco and of alcohol. It also includes general physiological information and, very importantly, sex education. Much of this may be best done in groups and at a community level.

Some of this has been a bit general and in this age everything seems to be in terms of bigness and mass production. Our individual patient may fit well into mass educational instruction classes, and accept readily general principles of hygienic living, immunization, etc., but he still needs and will universally express the desire for a definite and continuing medical adviser and guide. He needs something or someone to fill the role that had been filled previously by the G.P. or family physician. There may well emerge a modern version of the G.P. who may become the family medical adviser. The patient needs to be considered constantly as a person, not as a disease syndrome.

He needs also to be able to afford continuing medical care, perhaps better stated as continuing health supervision, as well as the occasional emergency attention in acute crises. In other words his health care must be economically feasible. And this is becoming rapidly a very major problem, accentuated by the steadily rising costs of labor, food, construction and provision of modern complicated technological equipment and procedures and multiple records and forms that must be tabulated and usually in triplicate. There have been quoted recently some, at least to me, astronomical figures and there have been some significant comments related thereto.³ Total expenditures for health care are now approaching \$50,000,000,000 annually, exclusive of the costs of medical education. This means the public is spending \$137,000,000 daily on medical care. Because of its costly diagnostic and therapeutic armamentarium, because of its degree of specialization, and because of the shared-financing, medicine, as an academic field and a practicing profession, must now respond somehow to the social and market pressures that operate on any giant industry.

A radical social contract has been forged in the past two years. It binds the profession, the government, the university, and the medical school in a new partnership. The degrees of freedom that medicine can reasonably expect to retain under this merger are obviously far less than heritage and tradition would lead us to want and expect. But we must remind ourselves that medicine brought on this dilemma by its wisdom in adopting a base of productive, scientific research.

It has kept its promise of becoming an ever more educated profession. In achieving this objective, it has become increasingly dependent upon an expensive education and technology which cannot be financed in the traditional manner. As a consequence, medicine must now engage in continuous bargaining with its public, through government.

These comments, ladies and gentlemen, are based on a presentation by Dr. Paul J. Sanazaro, Director of Education, Association of American Medical Colleges. They give one pause to think of many things, but they point a finger definitely at some of the causes of the rapidly increasing costs of medical care and emphasize that among our patient needs must be the ability to meet those costs.

Up to this point I have referred to a number of the more evident major needs of our patients and which may be enumerated very briefly and more concisely. He needs:

1. Confidence that he is receiving the best possible care.
2. Someone to answer when he calls.
3. Continuing health education and a communicative family medical advisor.
4. Available physical and technological facilities.
5. Economic feasibility of adequate and continuing health care throughout his life and even to include appropriate well planned, economically feasible extended care facilities.

So what do we do about it? Those of you who attended the recent clinical session of the American Medical Association in Houston, Texas may have seen Report A of The Council on Medical Service dealing with the topic *Comprehensive Planning of Health Facilities and Services*. This report reviewed the activities of the AMA and Federal legislation relative to comprehensive planning of health facilities and services since 1962. Its purpose is to inform the medical profession of its opportunities and responsibilities, both under P.L. 89-749 and in the general area of voluntary comprehensive health planning.

It concludes that planning, organization and distribution of health facilities and services are a prime responsibility of organized medicine—a responsibility that should be given

a higher priority among the various activities of medical societies at the state and local level. It urges state associations and component societies to place increased emphasis on activities as follows:

1. Liaison and representation with all governmental and voluntary agencies involved in the implementation of P.L. 89-239 and P.L. 89-749.

2. Promotion of and participation in voluntary comprehensive planning of health facilities and services.

3. Dissemination of informational materials on the significance of P.L. 89-239 and P.L. 89-749; provision of guidance for participation in comprehensive planning of health facilities and services at both the state and local levels.

4. Provision of a speakers' service consisting of knowledgeable physicians who would be prepared to advise local societies on planning activities.

5. Promotion of participation by members of the hospital medical staffs in the long range planning of the hospitals they attend, and coordination of institutional planning with community wide planning.

The House of Delegates accepted this report, with the amendment of a sixth activity as follows:

6. Continued effort by the medical

profession to improve Federal legislation in this area and to emphasize the importance of local control.

It is my belief that these six activities are essential but that they must include equivalently our colleagues in the nursing groups and also hospital administrators and the constantly increasing numbers of necessary paramedical personnel.

We must foster and guide through national, state and component society channels the organization of community non-segmented and unified health care teams, the members of which meet together, plan together and work together to provide adequate local health care, education and facilities without unnecessary duplication in any one of these areas. Each patient must be regarded and treated individually and must be shown a considerate united front with adequate and kindly explanation of facts and procedures. In these regards we might well consider for appropriate state action two items, about neither of which have I detailed information. The first is again an action of the AMA House of Delegates in Houston, Texas last November at which time there was approval of suggestions for the establishment of a Council of the Board of Trustees of the AMA to be responsible for developing areas of co-

operation with allied health professions and services. The second is the apparent existence in California of a Health Manpower Council operating under the aegis of the State Medical Association but including representatives of "all" health related fields.

In conclusion I would like to summarize my comments very briefly.

There are many health needs in Pennsylvania. Some of the major ones are delineated herein. The pattern of these needs will change from time to time so that we must plan a continuing cooperative team approach to their solution. Let's meet again and again and from time to time invite appropriate additions to our membership and communicate carefully considered conclusions, decisions and suggestions to the members of our component groups.

REFERENCES

1. Westcott, Lloyd B. (President, Board of Trustees of Hunterdon Medical Center, New Jersey): The Sick Person Needs. Report of the Third National Conference for Professional Nurses and Physicians, Coronado, California, February 1967.
2. Martin, Samuel P., M.D. (Provost, J. Hillis Miller Health Center, University of Florida): The Sick Person Needs. Report of the Third National Conference for Professional Nurses and Physicians, Coronado, California, February 1967.
3. Sanazaro, Paul J., M.D. (Director of Education, Association of American Medical Colleges): Emerging Patterns in Medical Education. Mayo Clinic Proceedings, December 1967.

NEEDS OF THE PATIENT AS SEEN BY THE NURSE

LUCIE S. YOUNG, Ph.D.

There is little doubt that the 1960's have brought to the general public a high level of sophistication in health matters—and with it an expectation for quality care from all health workers. Yet when the public becomes the patient, these expectations are often nebulous rather than clear-cut, emotional rather than intellectual. This is not difficult to understand since the very fact that the individual is a patient has moved him to the point where he is no longer "normal," no longer able to proceed in his activities as he has done. Whether he is physically incapacitated or whether the stress is largely emotional because of the uncertainty his illness has pre-

cipitated, the patient is forced into a degree of unaccustomed dependence on others. If he is hospitalized, the dependence is accentuated, sometimes to a ludicrous point.

Look at the average patient in the average hospital. From the moment he checks in, his privacy is invaded, his sense of security threatened. Questions of the utmost intimacy are asked and answers are expected. He signs releases to allow strangers to do things to and with his body without any clear understanding of what these things might be or what the results might entail. He is stripped of his clothes and valuables, symbols of his status in life, and frequently

dressed in garments which both offend his modesty and his sex image. He is tagged like a child or a puppy dog, and this, rather than his verbal identification is accepted as real. More often than not he shares a room with a complete stranger, whom he may not like and who becomes privy to his confidential conversations and intimate physical needs. The entire environment is strange, even the bed, and as his hospitalization progresses, he is trundled to more strange places and faced with more terrifying equipment. Explanations, other than those in written brochures, are seldom volunteered, and his questions are answered superficially, or in a jargon

he does not comprehend, or are fielded skillfully to a vague tomorrow or another person. And yet these are questions which involve his well-being, perhaps, in his eyes, his very survival.

Compounding the confusion for the patient are the multitude of human contacts into which he is forced. One popular writer has said that the traffic in a patient's room resembles that of a medium sized airport. Even a more accurate delineation is overwhelming. Studies by Hans Mauksch² indicate that a patient has 67 visits a day on the average. The fact that many of these visitors come uninvited, unidentified, and may be replaced the next day with a new series of strangers does not add to the patient's sense of security. It is not strange, therefore, that the patient frantically clings to an image of "his" doctor and "his" nurse as the two stabilizing factors in his new environment, unrealistic though this may be. Intellectually, the patient may accept the fact that health care is now a complex operation which requires a team of workers functioning at equal and varying levels, but emotionally he clings to his need to be understood and appreciated as an individual, at least by the doctor and nurse. This does not mean that he does not have concerns about his therapeutic plan or his physical care. He has just enough popular knowledge to question, but seldom has the courage to do so openly. He knows if he is hurt, or uncomfortable and both fears and resents this. But basically he has a childlike faith that medications, treatments and diagnostic procedures are administered by competent practitioners, and it requires a really unusual occurrence to make him doubt. Indeed, if he is treated as an individual, his faith is intensified, because he cannot believe that anyone caring about him will allow anything untoward to happen. Some psychologists feel that the mature adult entering the hospital tends to regress in his emotions. Dichter³ said that the patient views the doctor and nurse as temporary parents and looks to them for friendliness, gentle care, reassurance, sympathy, understanding, and explanations. Delay in answering the bell is rejection. Tensions between doctor and nurse are like divorce. This appears to be borne out by other studies. Most unfulfilled needs reported by patients in United States Public Health Service research⁴ seemed to stem from emotional in-

security and anxiety over being in the hospital.

What, then, is the nurse's role in meeting these patients' needs? Nursing, like any other profession, does not exist in a vacuum. It has been affected by changes in society and by changes in health practice. The increase in population alone augments the potential need for nurses. The unresolved problem of chronic and degenerative diseases combined with a longer life span has not only increased the number of older patients with these diseases in general hospitals, but has caused an enormous growth of nursing homes and stress on community facilities. In general, the public demand for more and better health care, combined with federal and state legislation has provided increased career opportunities for nurses and helped to pull many away from the hospital environment. This, in turn, means that fewer professional nurses serve an increased hospital population, and that different approaches to nurse utilization had to be developed. Part of the answer, and a not altogether satisfactory one, was the proliferation of auxiliary workers in nursing with a delegation to them of certain patient care activities.

Finally, of greatest impact, are the tremendous changes in health care due to continuing scientific advancements. The complexity of the care which evolved required, first of all, an intensified team effort, for even the physician could not provide all the needed equipment and facilities outside the hospital at a cost which was not prohibitive. A higher level of education and training with more emphasis on the physical as well as social sciences, was required of health workers to cope with newer techniques. And, finally, the physicians, fewer than ever per population ratio, and pressed by the increasing complexity and number of their own functions, began delegating to nurses functions previously performed only by themselves. The examples of such delegation are numerous, but perhaps the most recent and dramatic is pinpointed by the American Medical Association resolution passed in November which formally delineates from the physician's point of view the role of the nurse in cardiac resuscitation. Perhaps less startling, but just as meaningful, is the suggestion of Dr. Charles E. Lewis, head of the Kansas Regional Medical Program, that some nurses might be-

come the "general practitioners" for many chronically ill persons. Whether these roles are appropriate to nursing is naturally a matter for discussion, but serve here only as illustrations of the elasticity in the role as seen by the leader of the health team, the physician, and accepted by nurses. There is, however, one key point to be remembered in any discussion of the nurses' responsibility in meeting patient needs. If nursing is to be a true *profession*, it must determine its unique contribution to patient care. There is no doubt that the quality of nursing care has been diluted by the acceptance of administrative and other non-nursing tasks. But to satisfactorily meet the needs of patients, the nurse must remember that regardless of other changes, there is only one purpose for her professional existence, the patient. In order to fulfill her responsibility as a nurse and a member of the health team, the patient must remain her central focus.

To define the nurse's role in patient care today is not easy for it is as many faceted as the preparation and skills of nurses themselves. To avoid confusion, the professional nurse only will be discussed. In a recent study, investigating the functions of nursing in patient care, as seen by the physician, hospital administrator, patient and nurse,⁵ a number of general inferences are drawn relating to the nurse-role. It is pointed out that the nurse performs tasks which vary in complexity, with almost no upper or lower limit of participation designated. The nurses' responsibility to engage in certain nursing activities is frequently determined by the needs of the patient. Even if a particular task is delegated to another worker, the professional nurse is still responsible for all facets of nursing care; she must make the judgment about which level of nursing personnel can best be utilized in the performance of particular nursing activities for a particular patient. As a member of the health team, the nurse functions independently as well as interdependently. It is important that she be accepted by other participating professional groups as a colleague with a distinctive and individual contribution to make in meeting the patient's health problems. Since these needs are not limited to the patient's hospitalization, she cooperates with these groups in planning continuity of care and in promoting and maintaining community health.

Within these general premises, there are a number of specific components of nursing care. Nursing is, first of all, a clinical profession. Dr. Luther Christman⁶ states that the word "clinical" connotes the translation of basic science information into patient care. And the Nurse Practice Act of Pennsylvania identifies a professional nurse as a person "who performs any professional services requiring the application of principles of the biological, physical or social sciences and nursing skills in the care of the sick, in the prevention of disease, or in the conservation of health."

Without question, a primary clinical nursing service needed by the patient is the performance of therapeutic measures prescribed and delegated by the physician. In this role, the nurse functions in two ways—assisting the physician as he carries out a procedure and carrying out his orders in his absence or at his request. At one time, the emphasis on these tasks was on instant and unequivocal obedience; the nurse did as she was told and was not encouraged to question. The increasing complexity of medical and nursing care, however, has made such an attitude untenable. An understanding of cause and effect based on scientific principles is essential for safe and effective performance. The nurse may, within certain limits, manipulate complex equipment used in the diagnosis and treatment of patients, but more often a technical worker assumes this responsibility, and the nurse must instead exercise precise interpretive and judgmental abilities in the utilization of automated and monitoring devices. Knowledge of the actual functioning of the machine is only essential to the degree that the nurse recognizes that it is functioning accurately and reporting the patient's condition correctly. The nursing function is to interpret the patient's condition on the basis of the scientific knowledge the nurse has acquired, report it to the physician and/or take whatever action is necessary to aid the patient, depending on whether such action is part of her preparation. Although the classic example of a nurse recording accurately and frequently the vital signs of a dying patient without notifying the physician is one regarded with horror by nurses and physicians alike, it does serve to point out that the nurse, in her clinical role, is not an automaton, functioning mechanically. Precise judgment is re-

quired in every aspect of the clinical practice, whether the nurse is carrying out her one dependent function of following the physician's order or operating in the independent areas of nursing care. Legally and morally the nurse can no longer be an unquestioning handmaiden. Those physicians who have participated in the education of nurses in coronary care units and have worked with them, expecting them to make life-saving decisions never before entrusted to a nurse, recognize the highly specialized clinical nature of such practice. Yet less spectacular patient care decisions are made on other units daily and affect the patient's well-being as seriously. Nurse and doctor must work together in developing the patient's plan of care. The nurses' technical activities are performed meaningfully only in relation to the patient's total comprehensive plan of care.

Meeting the patient's physical needs by ministration is the aspect of nursing care most familiar to those with preconceived images of nursing. In its broadest sense it includes observation and interpretation of the patient's condition and practicing preventive and rehabilitative nursing measures to preclude further disease or deformity. While physical care, the longed for "tender touch," has often been delegated to subsidiary workers, it has not moved out of the sphere of the professional nurse's practice. It is, of course, accepted that the professional nurse give care to the patient with the more complex conditions, requiring careful manipulation and encompassing many other facets of nursing care. But the nurse appreciates that her frequent involvement with only the most seriously ill patient may also have a negative effect, causing patient and family to associate her only with crisis situations and unpleasant treatments.

Ministering to the patient's physical needs also gives the nurse an opportunity to ascertain other needs. She understands the interrelationship of psychosocial and physical factors in illness and gives physical care based on this understanding. By the way in which she carries out the patient's care, she demonstrates her respect for him as a human being. She relieves pain and discomfort, one of the strongest basic needs of human beings, but again considers his physical care as an integral part of his overall plan of care, which has been evolved

with the physician. Rehabilitative needs may require that the patient participate in his own care as much as possible, that he perform or has performed activities that are somewhat painful and uncomfortable initially. But the patient and his family, also a part of the health team, must become partners in care, being given full understanding of their role for the improvement of the patient's condition. The days of mysterious silence or evasive answers to patient's questions have vanished. The patient resents the clannish secretiveness of the professional health workers regarding *his* condition. It has been found that patients make better recoveries when they have an intimate knowledge of, and participation in the plan of care. Again the question of who tells the patient what is immaterial. The physician, whose overall responsibility is for the patient's total care, may have preferences about what he tells whom, but he can also be helped by the nurse's observations of patient mood and attitude and of family reaction to the patient's condition. Again, it must be a joint planning of care, with each team member performing a coordinated function.

New findings in the social sciences and continuous studies of patient needs have put an intensified focus on meeting the patient's psychosocial needs. In many ways these needs are closely associated with the patient's physical needs, for one cannot observe his mental and emotional conditions from a distance. Appreciating the abnormal situation of a hospitalized patient, displaced from his normal environment and activities and frequently losing his individuality, self-direction and control of activities, the nurse is constantly aware of how these factors affect his well-being. She is concerned with his mental health as well as his physical health; she hopes to provide for some of his social needs as well. Basic to all emotional support is true respect for individual differences in patients. Stronger than any other patient complaint is his protest against loss of his individuality. Although the nurse attempts to provide a physical, social and spiritual milieu conducive to the patient's well-being, she is again aware that this is not a task for her alone. She recognizes her limitations and involves other members of the health team whose preparation is in the appropriate area. Yet she is inevitably the

one in the best position to determine if the patient needs such services, for she has the longest sustained contact with the patient. A good nurse utilizes all possible opportunities to know the patient and ascertain his covert as well as overt needs, and there are certainly times when this information is obtained from others caring for the patient. To some, this aspect of nursing is the heart of services offered—the “care” component of the professional nurses’ function. A quote from the A.N.A. position paper can best summarize the foregoing activities:

“The essential components of professional nursing are care, cure, and coordination. The care aspect is more than “to take care of,” it is “caring for” and “caring about” as well. It is dealing with human beings under stress, frequently over long periods of time. It is providing comfort and support in times of anxiety, loneliness, and helplessness. It is listening, evaluating, and intervening appropriately.

The promotion of health and healing is the cure aspect of professional nursing. It is assisting patients to understand their health problems and helping them to cope. It is the administration of medications and treatments. And it is the use of clinical nursing judgment in determining, on the basis of patients’ reactions, whether the plan for care needs to be maintained or changed. It is knowing when and how to use existing and potential resources to help patients toward recovery and adjustment by mobilizing their own resources.

Professional nursing practice is this and more. It is sharing responsibility for the health and welfare of all those in the community, and participating in programs designed to prevent illness and maintain health. It is coordinating and synchronizing medical and other professional and technical services as these affect patients. It is supervising, teaching, and directing all those who give nursing care.”

One of the most sadly neglected functions of the nurse in meeting patient needs lies in the area of patient teaching. To some extent this involves the explanations and interpretation of the therapeutic plan of care noted previously, but it extends beyond such aspects. Because of the natural emotional involvement of the patient, teaching is not a simple explanation

or demonstration. Often he pretends understanding or grasps the knowledge briefly only to retreat to confusion. Interpreting and reinforcing the physician’s explanations and teaching are a vital part of the nurse’s activities and once more, require close cooperation and communication between the two. Applying the principles of the teaching-learning process, the nurse integrates into her plan of care appropriate opportunities to teach the patient and his family. She attempts to create an atmosphere conducive to learning, recognizing that emotional and physical disturbances prevent adequate learning. She adjusts the teaching plan to the patient’s individual needs, abilities, physical and emotional condition. She involves others in teaching, and in turn, includes the family in teaching appropriate preventive, therapeutic and rehabilitative measures. Appropriate measures to guide the patient toward self-care and independence are taught, and focus on his return to the community in the best possible state of well-being.

The nursing functions just discussed are easily related to patient needs. Less understood are the administrative and teaching functions which are a part of the role of today’s nurse. In one sense, they are the “off-stage” tasks related to patient care, for they do not occur at the bedside, but are nevertheless important to the patient’s well-being.

There is a tendency to think of administrative tasks as “paper-work” unrelated to patient care. It is true that such can be the case and that there are nurses devoted to ordering supplies, checking equipment, and writing requisitions. Administration of patient care is another matter. It involves planning, organizing, communicating, supervising, coordinating, and evaluating the patient’s total plan of care. As head of the nursing team, the professional nurse assumes responsibility for the patient’s plan of nursing care. In planning care, she pinpoints patient problems, obtaining knowledge of the patient from many sources, including her own observations. She surveys the physical and human resources available for carrying out the plan of care, and decides on an appropriate course of action on the basis of these resources, of her knowledge of nursing principles, the nursing diagnosis, and the physician’s plan of therapy. It is here that she exercises independent judgment in

planning an individualized regimen of nursing care, and fits it into the total plan of care. It is not a rigid plan, but designed to be flexible to meet the patient’s changing needs. Neither the planning or organizing of care is a solitary exercise, but one done in cooperation with others. The good nurse is able to distinguish which nursing tasks can be performed satisfactorily by individual workers and various levels of workers, but attempts to avoid fragmentation of care. She organizes time, personnel and material so that patients receive optimum care which is prompt and effective.

Essential to effective administration is a high level of communication skills. The nurse recognizes that communications with and about the patient are essential for effective patient-centered care. She communicates pertinent aspects of the patient’s condition to the physician, to other members of the health team, the nursing team and to non-nursing personnel in order to establish a therapeutic milieu for the patient. In turn, she appreciates and utilizes communications from others about the patient. Most important, she establishes rapport with the patient so that their mutual verbal and non-verbal communication is effective.

Good communication is equally vital in the nurses’ coordinating function. Since the nurse is “where the action is,” she finds herself in the natural role of coordinator—of services within and without the hospital. The multiplicity of services involved in returning a patient to health can cause confusion, duplication, and disorganization if coordination is not present. Therefore, the nurse must know of existing services, agencies, and other hospital and community resources available to the patient, sometimes making the contact, aiding the family to make the contact, or simply making such knowledge available. Above all, she recognizes that these resources are vital to continuity of care. Without coordination of patient care, little improvement is possible.

Development of satisfactory evaluation tools for patient care is lagging, but many informal measures can be and are used. Constant re-evaluation of the plan of care in relation to changes in the patient’s condition and nursing resources is necessary. The nurse may evaluate the results of specific nursing measures, the failure to apply appropriate nursing measures, or the patient’s overall reaction to nursing care. Inevitably, this results

in re-planning and organizing, often involves new teaching or improved supervision of auxiliary personnel. On other occasions, it involves another function of nursing—research. Although the nurse has participated and does participate in medical research, one of her responsibilities is the identification and formulation of new knowledge in her own field of practice. Whether simple or complex, research, properly interpreted and utilized, adds new dimensions to patient care. The collection, recording and correlation of clinical data allows the nurse to modify or change nursing care in the light of new knowledge. It is a function only lately growing in stature and strength.

Within this paper have been described the means by which the nurse can meet patient needs in this modern era of technology and science. Let it never be forgotten that no scientific techniques can replace common humanity, the “caring about” a patient. In Holliday’s doctoral study, a composite picture of the ideal nurse, as delineated by patients, emerged:

“She is qualified to the degree of being proficient. That is to say, she really knows her job. It’s most important for her to understand me; that is, she can put herself into my shoes, experience some of my problems. When she performs, she really has the air of *knowing* her job. While she is performing her work she expresses a sort of gentleness and friendliness. She is well informed in other than her major role responsibilities. She is congenial with others, even though I am her primary concern. She appears to be happy. I don’t mean that she is “bubbling over,” but she is a person who seems to be enjoying life. Whenever I need her most she is right there supporting me. I want to be able to really talk to her, and I expect her to be able to express herself well. Sometimes, even before I become uncomfortable, she will anticipate my needs and make me comfortable. When she performs a function she takes time to explain the “whys” and “hows” of it. She is always clean and well groomed; and, finally, I guess I do want her to feel sorry for me at certain times.”

It is not a simple task to fulfill this image, indeed far more complex than imagined by any patient, but nursing’s goal is, as it always was, to succeed in the task.

THE AMA POSITION

CHARLES L. LEEDHAM, M.D.

This is the second state level physician/nurse conference. There are three more planned. Oklahoma has one coming up next month; then there will be conferences in Texas and Florida, between now and May.

I think that the exploratory work for those three national conferences by the AMA and the ANA has been instrumental in encouraging state conferences. The first national conference was held at Williamsburg, Virginia, in the spring of 1964. The second one was held in Denver in the fall of 1965, and the third in Coronado, California, in February 1967. Your Chairman, Dr. Miller, was at that meeting. These were usually successful; they’ve broken the ice so to speak and have established communication, at least on a national level, between the physicians and the nurses and they’ve accomplished their purposes. Now the general theory and thought is that these should be extended to the state level and then eventually to the county level, so that we in Pennsylvania are actually in phase two of our original planning.

My subject today really is *AMA Support of Nursing*, and I’m going to try to approach it on the basis of history: What has been done by the Nursing Committee of the AMA and what is now being done. I’m also going to take another approach. I’m going to try to present it in two aspects of the AMA relationship to the nursing profession: policy and the activities and functions of the AMA Nursing Committee.

The AMA would have no reason for existence if it weren’t for patients. So its function is, if possible, to help furnish or set the stage for the best possible patient care. Or, if you want to put it in today’s industrial vernacular, it is the delivery of optimum medical care to all segments of the population. This is a pious enough objective or goal or whatever you want to call it, and would seem rather simple to accomplish, but there have been difficulties. The AMA support of the nursing profession is probably best stated in a paragraph which

is to be published in about two months by the AMA:

“If the medical and nursing professions are to make the fullest use of their joint potential, they must have not only a common denominator of interest in the patient, and a comparable body of knowledge, but also the kind of relationship that derives from a deeper appreciation of and respect for each other as allies working toward the same goal of optimal patient care.”

The AMA, in November, 1962, at its meeting of the House of Delegates, put it this way: “The AMA goes on record as supporting the nursing profession in its continuous efforts to promote the highest possible standards for nursing education and patient care.” In all of this, the AMA is justifiably concerned about the present acute shortage of nursing personnel. It believes that if the optimum nursing care is to be given, there must be a sufficient number of nurses to give that care, and this is one of our principal concerns. Therefore, the AMA has gone on record as supporting both adequate remuneration for nurses and an increase in the number of graduates from nursing schools to meet the demand for nursing service. Let’s take the first one first—adequate remuneration. In November, 1966, at the Las Vegas meeting of the House of Delegates, the AMA said that the AMA should support the need for a significant improvement in the income of registered nurses, recognizing that there will be considerable variation in compensation depending on the prevailing local conditions, training, experience, and the degree of delegated responsibility.

In the same meeting, the House of Delegates said that the AMA continues to support, in principle, all current nationally approved educational programs for nurses in the community. It is recognized that 70 percent of the nursing care at the present time is rendered by graduates of diploma schools. It agrees with the inclusion of nursing training in total community health planning, and with

the provision for greater and improved use of formal educational institutions—schools, colleges and universities, as well as in-hospital training. The present existing schools are not producing enough nurse practitioners. An effort should be made to stimulate all four levels of nursing education rather than to try to close out one or two of them and concentrate in a certain area, and this is why the AMA took that position and stand.

In June of 1967, at the meeting in Atlantic City, the AMA House of Delegates in a rather lengthy resolution re-affirmed its support of all forms of nursing education, including baccalaureate, diploma, associate and practical nurse education programs. In that same resolution it also commended diploma schools for their achievements, and, at the same time, asked them to increase their enrollment. It also asked professional nurse associations, all of them, and the American Hospital Association to encourage increases in diploma school enrollment. They worked on the theory at that time that the diploma schools were producing the bulk of the nurse graduates. They should therefore be supported until the situation can clarify itself so that nursing education can move into the university field. Now, although this implication was very strongly put, the AMA also supported baccalaureate programs. So you see, the AMA has recognized the fact that the practice of nursing as well as the practice of medicine is changing, and is getting to be more complex.

The Nursing Committee and the AMA are seriously concerned about the role of the office nurse. This group is the third largest group of employed registered nurses. These nurses, we feel, may be a potential reservoir of latent nurse power which

could be utilized for more effective patient care services in extended care facilities and the home, thereby saving physicians' time as well as giving needed nursing care to his patients. This approach would not mean asking the office nurse to leave the doctor's service, but in other words to extend her nursing ability to help him take care of his patients outside of the office in the long-term patient care facility and in the home.

A function of the AMA Nursing Committee at this time is the promotion of the nurse/physician conference. The Committee encourages the formation of state medical society nurse liaison committees. In connection with this thought, the Committee has published a brochure, entitled *A Guide for the Organization of State and County Committees on Nursing and Suggested Activities*, and that has received rather wide distribution and is available at the AMA to anyone who would like to have a copy. It is a very good book, and I think it has a lot of the points which we have learned in our ten or eleven years experience with nurse committee activities.

The Nursing Committee is to meet annually with the Committee Panel on Nurse Consultants to discuss problems of mutual concern and interest for the betterment of patient care. This is a "Blue Ribbon" Committee. It is, if you want to call it that, a "sounding board"—a consultant group. We discuss with its members the problems which we have before us and get their attitudes and wisdom on those problems. There are eight members on the Committee; four of them represent the four levels of nursing education; the other four represent the nursing service. Top-level nurses are represented on this committee and they are known all over the country in their own areas.

The AMA Nursing Committee is to meet yearly with the equivalent committee of the American Hospital Association to discuss problems of mutual interest in the betterment of patient care. The Committee is now producing a video tape on patient care—committee work on patient care to develop a background, a unit, which can be used in hospitals to develop patient care committees between physicians and nurses.

We have developed nine articles for publication in the Journal of the American Medical Association on nursing subjects. These are all being written by nurses in their special fields.

The committee has an education exhibit which is taken around the country and which tells principally the function of the AMA Nursing Committee and the relationship of physicians to nurses and to nursing problems.

We have secured nurse participation in three of the general section meetings of the Annual AMA Convention in San Francisco. A nursing subject will be presented as part of the section program in San Francisco in three of the clinical sessions.

The committee maintains contact with all nurse organizations—either by membership in the organizations, or committee membership, by attending conventions, and conferences as an invited auditor. I think we have good rapport with all of the nursing organizations. There are still differences of opinion, and this is perfectly normal human behavior, and I am sure they can all be settled because in the end we're all working for the same thing—better care for the patient, whether that care is given by physicians or nurses, and, together, I think we can improve that care 100 percent.

WORKSHOP REPORT DOROTHY J. NOVELLO, Ph.D.

I will speak first on the one charge that we were given when we started, "future meetings." Apparently all three groups did discuss the point, and the majority opinion favored continuation. There were some variations. Two of the groups felt strongly that

the meetings should be retained at a doctor/nurse level for a period of time, and that possibly in the future, after we have more carefully delineated specific concerns for this group, we might want to invite hospital administrators. Apparently there was

one group that felt hospital administrators should be included immediately as part of the joint meetings.

In considering at what "level" we should have the meetings, the decision seemed to point to all levels. We want to keep the state committees

because we feel state committees should be directing and coordinating local efforts. It would give the local, smaller, committees impetus and something to relate to, if they are operating in a state-wide venture. The groups recommend that committees might well be at regional levels, depending on the size of the area. We can see the possibility of committees being at county levels in the large counties with large county professional groups. We also see committees formed on a very local level, the hospital level—or hospital-community level. Therefore, the groups are recommending implementation of the same kind of communication, the same process, at a variety of levels.

As for "identifying problems," the problems identified by the group seem to center around such things as errors in medication, accidents and unusual occurrences, lost patients, etc. "Lost patients" were defined as persons who are in a private room, who are perhaps no longer critical, and consequently, rarely, if ever, see any nursing personnel. They become totally removed from the "nursing care" situation.

Personnel problems were introduced. In particular, the problem of nurses having to assume administrative functions and paper work which are not properly a part of their function, and which is really taking the nurse away from the foci of her true purpose for even existing—the patient. I think, as nurses, we all feel quite strongly that there is no doubt in our minds that nurses want to be with patients. The problem occurs in being relieved of the activities which keep us away from them. The statement, "nurses want to be with patients," initiated clarification from some group members, which I would support. The statement does not imply that nurses would do everything for the patient, but that we would be planning the patient's care and we would provide continuity in the kinds of care that the patient receives. We would be conferring with all people who would be interacting with the patient, a kind of a "team" approach. I think several groups brought out the advantages of "team nursing" in this respect, that there is an intercommunication with all people interacting. The groups added to the "team nursing" concept however by asking "how about the doctors being in on this and let's share the informa-

tion that we get in a team conference with the doctors." Ultimately, the nurse plans nursing care and may give it, if in her judgment she seems to be the best person to do so.

Back to the old problem of "why don't nurses make rounds with doctors anymore." The issue came up as a problem of communication, since groups feel that anything that would increase patient-centered communications between doctors and nurses would certainly feed into the welfare of the patient. One of the ideas presented was that perhaps the reason is that "rounds" were not really being utilized for communication. Doctor/nurse rounds didn't provide a mutual exchange of information but were more or less simply a one-way listening phone. The doctor wanted to know the answers to several questions when he made rounds, and the nurse felt that there were other ways for him to get the answers. Consequently, in establishing priorities, nurse/doctor rounds began to decline as an important priority. Most of the groups that I observed, and that the recorders reported on, seemed to support the concept of making rounds as a good avenue of communication, if, indeed, the rounds function as valid "inter-personnel" communication, and center on patient needs at the time.

Mention was made of the fact that patients place most of their confidence in the best prepared person who cares for them. From this, one group got into a discussion on preparation of various levels of practitioners in nursing, various ancillary personnel in nursing, the kinds of programs that are cropping up, the type of patients who are to be served, etc. The group felt that there was a strong need for doctors and nurses to cooperate in trying to control, defeat, or support legislation that would be conducive to developing the best possible health care pattern for the community. The group spoke specifically of vocational training funds and money that is freely available to school districts in which programs are cropping up with no evaluation as to the need for the program, or consideration of the fact that they are pulling important teaching personnel away from professional schools. Fortunately, someone else introduced it, but, as an educator, I was delighted to find out that there is a doctor in this meeting who is very cognizant of the fact that there is a critical shortage of nursing edu-

cators. Apparently we are all well aware of the shortage in nursing staff people, but we have just as critical, if not even a more critical, shortage of educators; if we don't have good educators, we cannot have good practitioners.

In addition to the problems identified previously, the groups discussed the fact that they felt that nurses and doctors should be involved in all phases of the evolving comprehensive health care planning at the state and national level and that they should have a better understanding of each other's abilities. In several instances, mention was also made of the hospital and the hospital's role. I believe that some participants felt that hospital administrators should be invited immediately because many pertinent problems are related to administrative practice. The groups felt that there was a strong need for employers of nurses to take some responsibility for ongoing or continuation of education for nurses and, for providing all types of refresher programs of the kind and nature that will be conducive to nurses returning to nursing. Refresher programs which emphasize the bizarre tend to frighten and discourage returning nurses. Employers should recognize that limitations of nurses do vary according to the individual abilities of nurses. We can't say that all nurses would be ready to come back after a refresher course or that all can operate as efficiently as one might expect or hope.

One discussion group was greatly concerned over who should provide tender loving care for the patient, and of course recognized that the doctor, to an extent, does provide, or should provide this. However, the group agreed that probably the person who is in the most unique position to provide TLC is the nurse. The fact is that the nurse is not providing TLC and, therefore, the "lack" presents a problem. The group felt that this problem was related to supply of nurses. The problem of nursing supply came up in all three groups, as you might suspect, and amazingly all groups identified similar causal factors. The groups seemed to recognize that perhaps the supply problem isn't as critical as the utilization problem, and that, perhaps, if we would concentrate on utilization, rather than on concerning ourselves wholly with supply, we might do ourselves a better turn. It was also brought to the at-

tention of the groups that there are many nurses who are not practicing nursing. Miss Allison from the State Board of Pennsylvania can confirm that we are a "feeder state." Pennsylvania prepares nurses to feed into the rest of the country. Ten percent to 11 percent of all the nurses in the nation are prepared in Pennsylvania, but they do not stay in Pennsylvania. We have four nurses leaving the state to every nurse that comes in. So, although we prepare a great number of nurses, we certainly cannot attract them. This almost forces one to look at "job enjoyment" or "job satisfaction." Salary is definitely a factor, for nurses have been underpaid in our state. However, I don't personally believe that salary is the only factor. I think there are other rewards that are important to nurses, such as human dignity, status, understanding, acceptance as a professional, which Pennsylvania has long lagged in, and I am convinced that these are some of the reasons why we lose nurses. The recent federal study on health manpower points out that there is really very little similarity between the shortage of doctors and the shortage of nurses. The shortage in doctors is due to the lack of schools to prepare them, as well as a lack of quality applicants. The shortage of nurses, if such there be, is not due to a lack of schools. We apparently have all the nursing schools necessary. As a matter of fact, most nursing schools have vacancies and could afford to take more students if more students applied. Nursing still manages to attract a reasonable percentage of graduates from high schools and I doubt if present numbers will ever be exceeded. Human nature being what it is, girls are not all going to be attracted into one particular field, and nursing is competing with very popular fields for women today that it did not compete with in the past. The fact is, and has been, that nurses do not stay in nursing and that the profession loses 50 percent to 60 percent of its practitioners to other fields or to their homes. The major problem is not necessarily what can we do to get more girls into nursing, but what can we do to keep the girls nursing once we have them there. This is where we seem to be losing our supply.

One group summed up very well by trying to show us in general what they thought the problems were: (1) we have to have better teachers to

teach nurses; (2) we have to do something about having more nurses enter the profession; (3) we ought to concern ourselves with programs of education for nursing; (4) we ought to concern ourselves with utilization to get nurses away from clerical duties, and (5) that we ought to be concerned with the need for more doctors. This group thought there were a lot of problems of mutual concern, and all problems and all communication of this group should center around patient needs. The factors identified only become problems because they do interfere with fulfillment of patient needs per se.

I asked all recorders "What was the tone of your group?" and they replied that the groups were very enthusiastic; that the groups enjoyed the sessions; and that members had many positive comments. I did "float" from group to group as assigned and I observed that the groups were very nice, polite, groups and very, very, guarded with each other. I am sure this is precisely what one would anticipate when groups like ours meet for the first time. There was just one comment made about doctors and patient care and this was "the shortage of doctors." Obviously we did tend to talk about patient needs in terms of what are the nurses doing, which I think is exactly what we've been doing for quite some time in both professional and popular literature. Very little effort was made to candidly analyze the role performance of doctors. I felt that this evasion was necessary—it's difficult to inter-act introspectively with strangers.

There were no specific recommendations about maintaining the same group membership at the state level. As a matter of fact, one recorder did suggest that the group thought there should be some movement in and out. As a quasi-psychologist, and there are enough of you here to support me on this, I would suggest that if you want to be productive, you should keep your group membership consistent for a period of time. Everytime you change groups, you end up with a nice polite group which looks for "what" to talk about. The prime purpose is that no one gets too touchy about the discussion and all go home feeling very happy. Perhaps if you would retain your group membership for at least some period of time, you might become very productive and might be able to give the state some

of the guidelines in patient care it needs to feed into local areas. Ultimately you may contribute to a revised concept of doctor/nurse cooperation in providing good patient care in Pennsylvania.

There were some excellent suggestions made for resolving some issues. Various hospitals have come out with new and exciting ideas. Mrs. Patterson acquainted us with some innovations used at her hospital. One of note is abolishing nursing notes and doctor's notes. The hospital has patient notes on which both nurse and doctor report. Of course, this system has all kinds of built-in advantages—one is that some doctors, not any of this group of course, but some doctors have the habit of writing notes on a patient's record every five or six days, or the day after discharge. The doctor finally comes in and dictates notes to be put on the patient's chart. If nurses and doctors are using the same records and the nurse dates her notes daily, it becomes quite obvious to anyone interested at the end of the time that the doctor put all of his notes on at the tail-end. Consequently, it almost forces one to communicate, to let each one know what is going on in the situation. I thought it was a rather clever little idea in that it would provide better written communication. Sometimes, one has to force people to do what is right. Doctors and nurses *must* communicate, even if by force.

There are hospitals that have recognized the problem and structured patient care committees. Some of these function effectively while some of them are red-tape hierarchal structures that have very little meaning, and certainly not much nurse representation. However, Dr. Young mentioned studies that are being done in hospitals where councils of nursing and councils of medicine are operating. Nurses and doctors work together through the councils on patient needs, and then together go to the administrator with patient care problems, or, as Cliff Jordan said so very well, "the doctor isn't going in the front door, the nurse in the back door; you both walk in the front door together and face the administration with problems that you can see involving patient care in that particular hospital."

It appears to have been a profitable and exciting experience for all participants and hopefully, the first one of many more to come.



Let's be specific about Campbell's Soups... and reducing diets

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101





burning



itching



discharge



of trichomonal vaginitis...

Flagyl[®]

tablets/inserts

brand of

metronidazole

brings

- clinical cures
- microscopic cures
- culture cures

For the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

Among the few patients who do not respond to Flagyl are those who may not have taken the prescribed dosage and those who may have been reinfected.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

SEARLE

Research in the Service of Medicine

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor).....	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B ₁₂ activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.).....	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate).....	110 mg.
Ascorbic Acid (Vitamin C).....	75 mg.
Folic Acid.....	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B₁₂ therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B₁₂ (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B₁₂. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B₁₂, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic

*You can treat combined
deficiencies with*

Trinsicon®

—the multifactor hematinic



Vitamin B₁₂ plus intrinsic factor (15 mcg. B₁₂ activity)—helps provide adequate levels of this important vitamin.



Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.



Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.



Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500.

[032568]

Additional information
available to physicians
upon request.

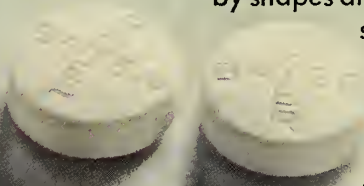
Eli Lilly and Company,
Indianapolis, Indiana 46206.

801668

Lilly



Tower of Babble



Are your patients confused by ad claims?
by shapes and sizes? by strange-
sounding ingredients?
When they need fast
relief from pain, you
can reassure them that
aspirin is still the
strongest analgesic they
can buy without your
prescription. And
Bayer is 100% aspirin.
No wonder Bayer works wonders.

the ^{In peptic ulcer:} antacid puzzle



solved by
Mylanta®
aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

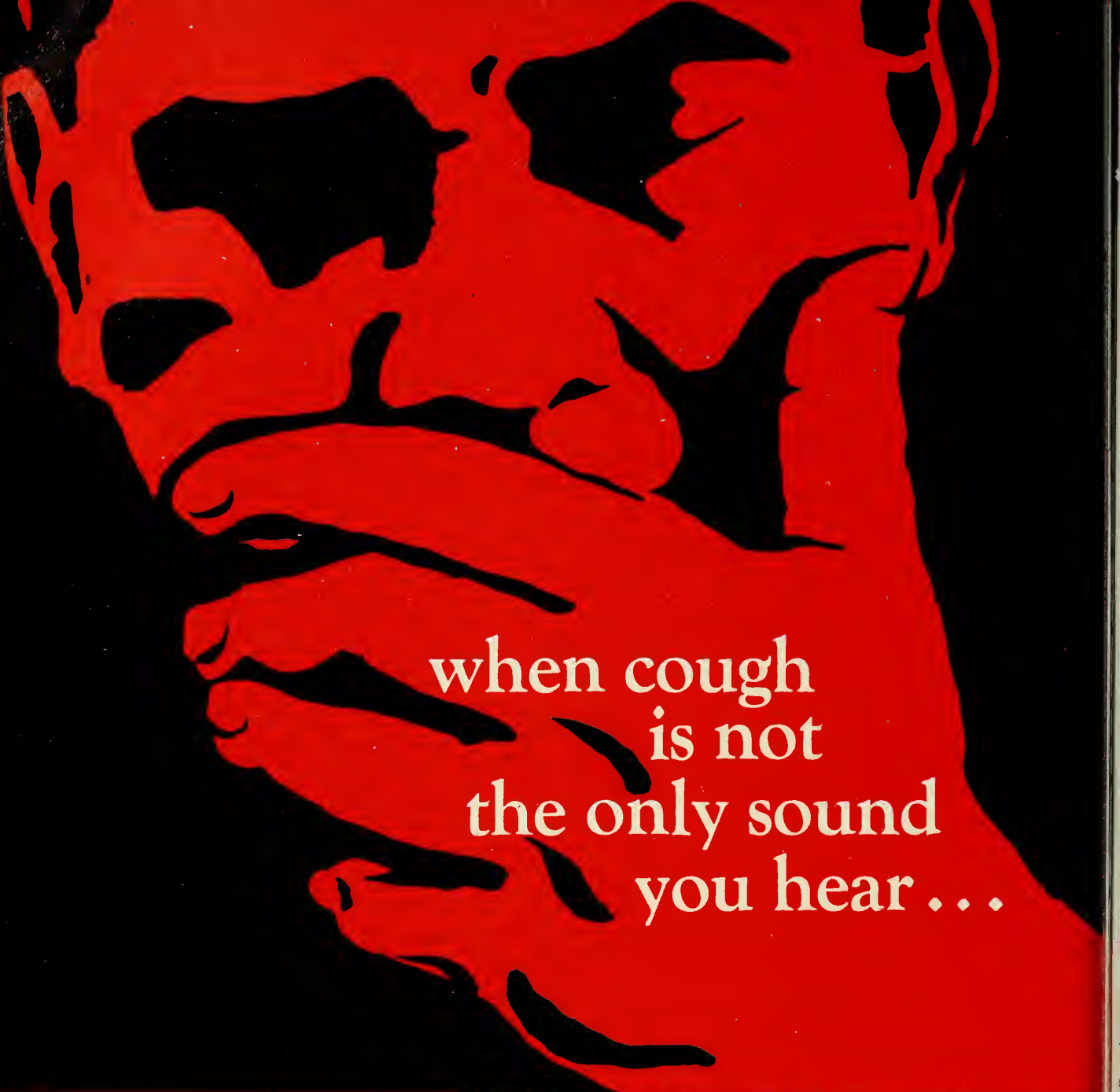
"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients — after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.



when cough
is not
the only sound
you hear...

OMNI-TUSS® b.i.d.

... **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.

Children (6-12 years): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strassenburgh

Strassenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.



⊙ Indicates courses being conducted in Pennsylvania.

CARDIOVASCULAR DISEASE

The Metabolic Basis of Heart Disease; by the American College of Physicians; at Wayne State University School of Medicine, *Detroit, Michigan, Thursday, September 26-29, 1968*; fees: members \$60, non-members \$100. Contact Edward C. Rosenow, Jr., M.D., American College of Physicians, 4200 Pine St., Philadelphia 19104.

GENERAL MEDICINE

⊙ **Practical Application and Treatment of Diabetes, Heart Disease, Ulcerative Colitis;** Annual Meeting of Blair County Chapter of AAGP; at Penn Alto Motor Hotel, *Altoona; Saturday, September 7, 1968*; AAGP credit applied for—4 hours; fee \$50.00; minimum number required 50; maximum number permitted—unlimited. For further information contact Philip W. Hoovler, M.D., The Altoona Hospital, Altoona 16603.

⊙ **Continuing Education;** at *Pottsville Hospital; Thursday, September 12, 1968 to June 1969*; one day per month, 10 months; no fee; AAGP credit 20 hours. Contact E. W. Cubler, M.D., Pottsville Hospital, Pottsville 17901.

⊙ **Retraining Program for Women Physicians;** by Women's Medical College of Pennsylvania, at *Philadelphia, Monday, September 23, 1968-May 28, 1969*; 672 course hours; no fee (stipend offered); minimum required 5, maximum 10. Contact Ethel Weinberg, M.D., Assistant to the Dean, Woman's Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia 19129.

⊙ **Recent Advances in Medicine;** at Temple University Health Sciences Center, *Philadelphia, Wednesday, October 16, 1968*, 8 days, 32 hours; fee \$50. AAGP credit applied for. Contact Albert J. Finestone, M.D., Temple University Health Sciences Center, Broad & Ontario Sts., Philadelphia 19140.

GERIATRICS

⊙ **Training in Geriatric Psychiatry;** by Coatesville Veterans Administra-

tion Hospital. Four months to one year training program for physicians. Program involves group and individual psychotherapy with geriatric patients, milieu therapy, physical rehabilitation, drug therapy, family therapy, and post-hospitalization care. Contact Kurt Wolff, M.D., Veterans Administration Hospital, Coatesville, Pa. 19320.

IMMUNOLOGY

⊙ **Immunity—How Much and to What?** A review of the modern concepts of the measurement and identification of immunity and the use of immunoproteins in diagnosis; by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, September 19, 1968*; fee: \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Full day visit with afternoon rounds. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

INTERNAL MEDICINE

⊙ **Electrolyte Metabolism and Renal Disease;** by Pennsylvania Medical Society; at *Chatham Center, Pittsburgh; Sunday and Monday, October 27 and 28, 1968*; fee for course \$25, non-members \$35. Nurses and Paramedical Seminar on Renal Diseases, *Monday, October 28*; Specialty Society Meetings, *Tuesday, October 29*. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

⊙ **Current Concepts of Thyroid Disease;** by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, October 24, 1968*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Two day visit, October 24 and 25. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

Basic Mechanisms in Internal Medicine; by the American College of Physicians; at *Medical College of Virginia, Richmond; Monday, October 7-*

11, 1968; fees: members \$60, non-members \$100. Contact Edward C. Rosenow, Jr., M.D., American College of Physicians, 4200 Pine St., Philadelphia 19104.

NEUROLOGY

Course in Clinical Electroencephalography; by American EEG Society; in *San Francisco, California; Monday, September 9-11, 1968*. Contact Donald W. Klass, M.D., Mayo Clinic, Rochester, Minnesota 55901.

⊙ **The Neurologist Looks at Stroke;** (Modern approaches to diagnosis and care); by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, September 26, 1968*; fee: \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

⊙ **The Neurosurgeon Looks at Stroke;** (The acute approach to repair and prevention of spread); by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, October 3, 1968*; fee: \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Two day visit, October 3 and 4. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

Current Concepts of Neurology—Diagnosis and Treatment; by the American College of Physicians; at *University of Maryland School of Medicine, Baltimore, Monday, October 12-25, 1968*; fees: members \$60, non-members \$100. Contact Edward C. Rosenow, Jr., M.D., American College of Physicians, 4200 Pine St., Philadelphia 19104.

OPHTHALMOLOGY

⊙ **Management of Retinal Detachment;** by University of Pittsburgh School of Medicine and Eye and Ear Hospital, *Pittsburgh; Monday, July 29-August 2, 1968*. Course limited to ophthalmologists. Fee \$250. Contact W. G. Everett, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

Post-Graduate Courses for Specialists in Ophthalmology; at *New York Eye and Ear Infirmary*; September 4—December 4, 1968; contact Jane Stark, Registrar, Post-Graduate Institute of New York Eye and Ear Infirmary, 310 East 14 St., New York 10003.

OTOLARYNGOLOGY

Course in Laryngology and Bronchoesophagology; by the department of otolaryngology, College of Medicine of the University of Illinois; at new Illinois Eye and Ear Infirmary, 1855 West Taylor St., Chicago, Monday, September 23-October 4, 1968. Limited to 15 physicians. Contact Albert H. Andrews, Jr., M.D., College of Medicine, University of Illinois, Post Office Box 6998, Chicago, Illinois 60680.

PEDIATRICS

Institutes for Physicians and Nurses in the Care of Premature and Other High-Risk Infants; being continued at the New York Hospital-Cornell Medical Center under the sponsorship of the New York State Department of Health and the U.S. Children's Bureau. Institutes for the 1968-1969 fiscal year have been scheduled as follows: *Physicians* September 16-27, 1968; November 11-22, 1968; January 20-31, 1969; March 17-28, 1969; May 12-23, 1969; *Nurses* September 3-27, 1968; October 28-November 22, 1968; January 6-31, 1969; March 3-28, 1969; April 28-May 23, 1969. Tuition is covered through a special arrangement with the New York Hospital-Cornell Medical Center. A stipend of \$125 is provided to physicians attending the institute to help cover board and lodgings for the two weeks. A stipend of \$175 is provided to nurses for four weeks attendance. Travel expenses must be covered by the participant or by his or her sponsoring agency.

○ **Up to the Minute Pediatrics;** by Woman's Medical College of Pennsylvania at Philadelphia, September 1968-May 1969; 4 to 5 hours monthly for seven months; fee: \$5.00 per session (lunch included). Contact Ethel Weinberg, M.D. Assistant to the Dean, Woman's Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129.

○ **Sudden and Unexpected Death in Infancy—A Major Practice Problem;** by Jefferson Medical College and

York Hospital; at *York Hospital*, Thursday, October 31, 1968; fee \$50 for 112 hours, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

PHYSICAL MEDICINE

○ **The Physiatrist Looks At Stroke;** by Jefferson Medical College and York Hospital; at *York Hospital*, Thursday, October 10, 1968; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

PSYCHIATRY

○ **Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *Reading Hospital*, Wednesday, September 11-December 11, 1968. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

Emotional Aspects of Illness; by The Institute of the Pennsylvania Hospital, at Morristown Memorial Hospital, Morristown, N.J., Wednesday, September 25-December 18, 1968. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Graduate Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *The Institute*, Thursday, September 26-December 19, 1968. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Medical Hypnosis;** by The Institute of the Pennsylvania Hospital, at *The Institute*, Thursday, September 26-February 20, 1969. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Sexual Problems in Medical Practice;** by Hahnemann Medical College and Hospital of Philadelphia, Wednesday, September 25-November 27, 1968. Contact Paul J. Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *The Institute*, Thursday, September 26-December 19, 1968. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Psychotherapy for General Practitioners;** by Hahnemann Medical College and Hospital, at *Harrisburg*, Tuesday, October 1-December 7, 1968. Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Psychiatric Problems of Children for Pediatricians and General Practitioners;** by Hahnemann Medical College and Hospital of Philadelphia, Wednesday, October 9, 1968-February 1969. Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Sexual and Psychosomatic Problems in Medical Practice;** by The Institute of the Pennsylvania Hospital, at Community Medical Center, East, Scranton, Wednesday, October 9-December 18, 1968. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Medicine, Psychiatry and the Law;** by The Institute of the Pennsylvania Hospital, at *The Institute*, Wednesday, October 9-December 11, 1968. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

SURGERY

○ **Surgical Anatomy and the Techniques of the Temporal Bone;** by University of Pittsburgh School of Medicine and Eye and Ear Hospital; *Pittsburgh*, Sunday, September 15-21, 1968, Sunday, November 17-23, 1968. Attendance limited to 13 physicians; fee \$500/week; contact Ralph J. Caparosa, M.D., 3600 Forbes Avenue, Pittsburgh 15213.

GENERAL

Research Instrumentation; at Polytechnic Institute of Brooklyn, N.Y. Saturday, July 20 through August 10, 1968; fee \$450. Contact Prof. K. R. Jolls, Polytechnic Institute, 333 Jay St., Brooklyn, N.Y. 11201.

● All organizations presenting continuing education programs for physicians are invited to list details of these programs in PENNSYLVANIA MEDICINE. Programs will be listed up to one year in advance. Information must be submitted three months in advance to assure publication. Please submit a separate request for each program. Continuing Medical Education Publication Request forms are available from the PMS Council on Scientific Advancement, Taylor Bypass and Erford Road, Lemoyne, Pa. 17043.

UNIVERSITY OF PENNSYLVANIA
DIVISION OF GRADUATE MEDICINE
SCHOOL OF MEDICINE

Presents a Course in

MEDICAL HYPNOSIS

BEGINNING SEPTEMBER 26, 1968

3:00 - 7:00 P.M., Thursdays

TUITION \$150

20 Weekly Afternoon Sessions

The course is open to all graduate physicians. It consists of lecture, demonstration, and supervised practical work in hypnosis totaling 80 hours.

For further information contact:

Office of the Director, Division of Graduate Medicine
237 Medical Laboratories
University of Pennsylvania
Philadelphia, Pa. 19104

THE INSTITUTE OF THE PENNSYLVANIA HOSPITAL
PRESENTS A COURSE IN

APPLIED OFFICE PSYCHIATRY

BEGINNING SEPTEMBER 26, 1968

3:00 - 7:00 P.M., Thursdays

12 Weekly Afternoon Sessions

TUITION \$50.00

This course is open to all graduate physicians and consists of lectures, demonstrations, and practical work on basic concepts and clinical application designed to give the maximum useful information to the practicing physician who is interested in improving his ability to manage the psychiatric problems commonly encountered in the practice of medicine.

For further information contact:

Sydney E. Pulver, M.D., Course Director
The Institute of the Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa., 19139



write now

Pamphlets: *Physicians' Publication List*, gratis from the AMA Committee on Cutaneous Health and Cosmetics, 535 North Dearborn Street, Chicago 60610. . . *The Cigarette—A Dubious Companion*, available at 20c each from the AMA Order Department, 535 North Dearborn Street, Chicago 60610. . . *Motorcycles in the United States*, single copies available free from the Office of Information, National Center for Urban and Industrial Health, Cincinnati, Ohio 45202. . . *Poison Ivy, Oak, and Sumac*, single copies free from the Information Office, National Institute of Allergy and Infectious Diseases, Bethesda, Md. 20014. . . *Exercise and Weight Control*, limited copies are available free, upon request, from the AMA Committee on Exercise and Physical Fitness, 535 North Dearborn Street, Chicago 60610. . . *Fads, Myths, Quacks—and Your Health*, available for 25c from the Public Affairs Committee, Inc., 381 Park Avenue South, New York, N.Y. 10016. . . *When to Call or See Your Physician*, quantity orders are available from the AMA Order Department at 12c each for 100-499 copies, 535 North Dearborn Street, Chicago 60610.

Booklets: *Questions and Answers about Public Assistance in Pennsylvania*, available from Community Services of Pennsylvania, 300 North Second Street, Harrisburg, Pa. . . *A List of Worthwhile Life and Health Insurance Books*, single copies free of charge from the Health Insurance Institute, 277 Park Avenue, New York, N.Y. 10017. . . *Organization and Management of Family Practice*, available to AAGP members gratis, \$1.00 per copy to others, from the American Academy of General Practice, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

To fight TB- find it first!

Make tuberculin testing routine
with every physical examination.



TUBERCULIN_(Rosenthal) TINE TEST

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



330-B/6135

THE INSTITUTE OF THE PENNSYLVANIA HOSPITAL

PRESENTS A COURSE IN

MEDICINE AND THE LAW

BEGINNING OCTOBER 9, 1968

1:00-3:00 P.M., Wednesday

10 Weekly Afternoon Sessions

TUITION: \$50.00

This Course is open to all graduate physicians and consists of lectures and discussion on legal questions of vital interest to the practicing physician. Doctor Jonas Robitscher, practicing psychiatrist and lawyer, will conduct the course.

For further information contact:

Sydney E. Pulver, M.D., Course Director
The Institute of the Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pennsylvania 19139



○ Indicates membership in the Pennsylvania Medical Society at time of death.

Leonard M. Arons, Pittsburgh; University of Pittsburgh School of Medicine, 1926; age 64; died May 17, 1968. Dr. Arons was a member of Phi Delta Epsilon medical fraternity and served with the U. S. Army Medical Corps during World War II. Survivors include four sisters.

James I. Borland, Cresson; University of Pittsburgh, School of Medicine, 1928; age 65; died April 24, 1968. Dr. Borland was on the staff of Lawrence S. Flick Hospital, Cresson, from 1942 until his retirement in 1965. Surviving are his wife and two daughters.

Grantville Clark, Philadelphia; Temple University School of Medicine, 1920; age 73; died May 7, 1968. Dr. Clark served as a medical officer during World War I. He is survived by his wife and a brother.

Laurence M. Codori, Philadelphia; Temple University School of Medicine, 1921; age 72; died April 19, 1968. Dr. Codori was a director of Physicians and Surgeons Hospital and a staff member of St. Mary's Franciscan Hospital. Survivors include his wife, three daughters and two sons.

○ **William E. Grove**, Johnstown; Jefferson Medical College, 1913; age 79; died April 14, 1968. Dr. Grove had been chief of the ear, nose and throat service at Memorial Hospital until he transferred to the active consulting staff. He served as a captain in the Medical Corps during World War I. We have received no information regarding survivors.

○ **Savere F. Madonna**, Philadelphia; Temple University School of Medicine, 1926; age 66; died April 28, 1968. Dr. Madonna was medical director of Northeastern Hospital. Surviving are his wife, a daughter, his mother, eight sisters, two brothers and three grandchildren.

○ **LeRoy M. A. Maeder**, Philadelphia; University of Minnesota School of Medicine, 1922; age 70; died April 15, 1968. Dr. Maeder was a past president of the Philadelphia Psychoanalytic Society and helped found the Philadelphia Psychoanalytic Institute. He is survived by his wife, a daughter, two sons and two brothers.

Robert E. Edwards, Glenshaw; Georgetown University School of Medicine, 1931; age 63; died April 28, 1968. Dr. Edwards had been associated with the Out-Patient Clinic of the Veterans' Administration Hospital, Pittsburgh, for twenty years. He is survived by his wife, two daughters, two sons, five sisters and a brother.

○ **Joseph H. Cloud**, Philadelphia; Jefferson Medical College, 1892; age 95; died April 27, 1968. Dr. Cloud was on the staff of Bryn Mawr Hospital until his retirement. He was a veteran of World War I. Surviving are his wife, a son, a daughter and three grandchildren.

○ **John L. Groh**, Lebanon; University of Pennsylvania School of Medicine, 1912; age 79; died April 15, 1968. Dr. Groh was associated with Lebanon Valley General Hospital for fifty years and was chief of staff there. Surviving are his wife, two daughters, two sons, three sisters and five grandchildren.

○ **Edward F. McDade**, Scranton; Temple University School of Medicine, 1928; age 69; died April 14, 1968. A member of the board of Mercy Hospital, he served in the medical student Army Training Corps in World War I. Surviving are his wife, three daughters, a son, two sisters, four brothers and six grandchildren.

○ **Donald W. Briceland**, Rimersburg; Western Reserve University School of Medicine, 1935; age 60; died May 3, 1968. Dr. Briceland was active in planning and designing the Rimersburg Medical Center and he served as the facility's director since it opened in 1957. He was a past president of the Clarion County Medical Society. Surviving are his wife, a son, a daughter, his mother and a grandchild.

○ **John E. Davis, Jr.**, Bryn Mawr; Jefferson Medical College, 1933; age 60; died May 2, 1968. Dr. Davis was professor of psychiatry and associate head of that department at Jefferson Medical College. From 1958 to 1963 Dr. Davis was Pennsylvania State Commissioner of Mental Health and deputy secretary of Public Welfare. He is survived by his wife and a daughter.

○ **Patrick M. Berzito**, Blossburg; Marquette University School of Medicine, 1943; age 49; died May 8, 1968. Dr. Berzito was a member of the Blossburg State Hospital staff and also of the Soldiers and Sailors Memorial Hospital in Wellsboro. He was a member and past president of the Tioga County Medical Society.

○ **T. Raymond Foley**, Wilkes-Barre; New York Medical College, 1951; age 44; died April 29, 1968. Dr. Foley was chief of the department of obstetrics and gynecology at Wyoming Valley Hospital and a Fellow of the American College of Surgeons. He is survived by his parents, his wife, five sons, a brother, and four sisters.

○ **Robert P. Gouldin**, Wallingsford; Hahnemann Medical College, 1943; age 50; died April 30, 1968. Dr. Gouldin was chief of obstetrics and gynecology at Crozer-Chester Medical Center and associate professor of ob-gyn at Hahnemann Medical College. Survivors include his wife, a daughter, two brothers and a grandchild.

○ **William E. Krewson, III**, Philadelphia; University of Pennsylvania School of Medicine, 1934; age 59; died May 2, 1968. Dr. Krewson was a past president of the American Orthoptic Council and attending physician at Wills Eye Hospital. His wife survives.

○ **John L. Lavin**, Wilkes-Barre; Jefferson Medical College, 1915; age 76; died May 13, 1968. Dr. Lavin was a medical examiner for the Swoyersville schools and for the New York Life Insurance Company. Surviving are five daughters, four sons, three sisters and several grandchildren.

○ **Leonard Pachman**, Philadelphia; Temple University School of Medicine, 1962; age 31; died January 27, 1968. We have received no information regarding survivors.

○ **Albert Sickman**, Charleroi; University of Pittsburgh School of Medicine, 1912; age 79; died May 18, 1968. Dr. Sickman was a former chief of staff at Charleroi-Monessen Hospital and a member of the emeritus staff there at the time of his death. Surviving are his wife and a sister.



PHYSICIANS WANTED

Attention: Physicians wishing to relocate and young physicians wishing to establish a rewarding practice in general medicine, internal medicine, obstetrics, gynecology, pediatrics, surgery, contact: A. W. MAYER, Administrator, The Titusville Hospital, Titusville, Pa. (814) 822-2291.

Physicians—part or full time. Student and Employee Health Service. Medical School hospital affiliation. Faculty appointment. Salary commensurate with qualifications. Submit curriculum vitae. P-31, P. O. Box 2066, Philadelphia, Pa. 19103. An equal opportunity employer.

Emergency Room Physician: Join private Emergency Room group in 100-bed general hospital located in South Jersey, one-half hour from Philadelphia. Minimum guarantee plus private billings. Must be eligible for or possess a New Jersey license. Write or call DR. JAMES H. SPIRO, West Jersey Hospital-Southern Division, Townsend Avenue and White Horse Pike, Berlin, New Jersey. Area Code (609) 767-5500.

Physician Wanted: Excellent opportunity for general practitioner, Emporium, Pa. County seat in northern area of State, center of hunting and fishing. Prosperous community, diversified industry, modern hospital facilities available. GP with large active practice retired, offices available. Contact EMPORIUM CHAMBER OF COMMERCE, 105 E. Fourth St., Emporium, Pa. 15834.

General Practitioner: Urgently needed. Community located in Northwest Pennsylvania. Population 6,200, drawing capacity 20,000. Fully accredited 70-bed hospital, new addition to be added. Eight miles from beautiful Kinzua Dam Recreational Area. Contact ADMINISTRATOR, Community Hospital, Kane, Pa. 16735.

House Physicians—Limited openings for house officers available. Salary \$18,000 per year. 274-bed accredited general hospital. Must be eligible for or have licensure in Pennsylvania. Write: OFFICE OF ADMINISTRATOR, Lower Bucks Hospital, Bristol, Pa. 19007.

GP and internist needed by expanding seven-man group; practice in city of 12,000 with a trade area in excess of 50,000; 90 miles from Minneapolis and St. Paul; excellent schools, including State Junior College; center of vacation area of many lakes; winter ski facilities 30 minute drive; 18-hole golf course, grass greens; 100-bed approved, expanding hospital with resident pathologist and three radiologists; 30 days annual vacation; time off for study; good salary first year, then full partnership. If you are tired of the pressures of the big cities and if this interests you for present or future planning, write to: THE WILLMAR CLINIC, Willmar, Minnesota 56201.

Associate—general practitioner, young, to join two general practitioners in Central Pennsylvania. Modern office, good hospital facilities. Salary first year then partnership. No expenses. Write Department 526, PENNSYLVANIA MEDICINE.

House physician for 202-bed general hospital, located in a growing university community, 55 miles from Pittsburgh. Rotate services with other house physicians. Pennsylvania license required. An excellent introduction to a community with good practice opportunities. Contact ADMINISTRATOR, Indiana Hospital, Indiana, Pa. 15701.

Wanted: Full time industrial physicians for permanent employment in du Pont Company plants in various states. Career positions. Excellent opportunity. General practitioners preferred. Salary open. Immediate open-

ings. An equal opportunity employer—male/female. Call collect or write to: C. A. d'ALONZO, M.D., Medical Director, E. I. du Pont de Nemours and Company, 11400 Nemours Building, Wilmington, Delaware 19898, (302) 774-6234.

House Physicians (3) needed at 235-bed JCAH accredited short-term, general hospital in suburban Philadelphia. Established educational program and residency in general surgery. \$13,500 per annum plus benefits. Excellent practice opportunity in growing area. Contact: BRUCE R. MARGER, M.D., Sacred Heart Hospital, 1430 DeKalb Street, Norristown, Pa. 19401.

Grove City Area—physicians needed, specialists or G.P.s. Drawing population 20,000. Have no ophthalmologist, orthopedist, urologist, Ob-gyn, pediatrician, internist. Have one general surgeon. Need G.P.s also. Bids being accepted to build new medical offices immediately adjacent to hospital. No limit on number. Nearest hospital to intersection of interstate 79 and 80. Rt. 80 complete in 1970. The expansion of Grove City College and Slippery Rock State College has already made its impact felt. Hunting, fishing, boating, 15 minutes away. Contact Richard McLachlan, M.D., Grove City Hospital, Grove City, Pa. 16127.

Emergency Room physicians needed for full-time staffing. Ideal for the new graduate or for the experienced physician wishing to slow down. Write ADMINISTRATOR, Sharon General Hospital, Sharon, Pa.

CLASSIFIED ADVERTISING INFORMATION

RATES—\$10.00 per insertion up to 30 words; 40 cents each additional word; \$1.00 per insertion for answers sent in care of Pennsylvania Medical Society. Payable in advance.

COPY DEADLINE—Copy due by the first day of month preceding month of publication. Send to Pennsylvania Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pennsylvania 17043. The right is reserved to reject or modify copy to conform with publication rules.

DEPARTMENT NUMBERS—Advertisers using department numbers forbid disclosure of their identity. Written inquiries are forwarded to such advertisers.

WORD COUNT—Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one, and "Write Department . . . , Pennsylvania Medicine," as five.

classified

House Officers: Physicians in good standing to cover accident and emergency service. Excellent opportunity for young or retired physicians. Fees and hours open. Contact ADMINISTRATOR, North Penn Hospital, Lansdale, Pa. 19446. Location—25 miles north of Philadelphia.

Psychiatrist—full-time 700-bed hospital containing two geographic units and geriatrics-infirmity unit. Community oriented program. Located six miles from downtown Pittsburgh, medical school, psychiatric and analytic institute. Opportunities exist for faculty appointment, personal analysis or analytic training. Pennsylvania licensure required or eligibility for licensure. Requirements: two years experience and completion of three years residency—\$17,839-\$20,629. Completion of three years residency only—\$16,170-\$18,725. Write SUPERINTENDENT, Dixmont State Hospital, Glenfield, Pa. 15115.

Associate Radiologist to be available July 1, 1968, Charleroi-Monessen Hospital, North Charleroi, Pa. 15022. Must be Board Certified or Board Eligible, American College of Radiology. Primary duties to assist Chief

Radiologist. Hospital consists of 211 beds plus 24 bassinets and is in a developmental-expansion program. The Department consists of 6 registered technicians plus ancillary personnel. Salary: \$25,000 per year minimum—negotiable. Liberal fringe benefits including 30 days annual vacation and sick leave plus 14 days per year to attend educational meetings. The hospital will defray up to ½ the expense for personal interview. Direct all responses to the ADMINISTRATOR.

Emergency Room Physician—Full time. Accredited 300-bed general hospital; affiliated with the Guthrie Clinic; active internship and residency program; excellent benefits. Located in Northeastern Pennsylvania, 20 miles east of Elmira, New York. Write ADMINISTRATOR, Robert Packer Hospital, Sayre, Pennsylvania 18840. (717) 883-9251.

Orthopaedic Surgeon wanted—Associate for well established orthopaedic clinic in Eastern Pennsylvania. Under 34 years. Partnership after 1½ years. No investment needed. Board eligibility required. Write Department 513, PENNSYLVANIA MEDICINE.

Emergency Department Physician— Pennsylvania license required, 40 hour week, \$2000 monthly guaranteed, P.E.D.S.A., Rochester General Hospital, Rochester, Pa. 15074.

Internists, general practitioners, radiologists wanted to group medical practice in inter-city Philadelphia. Prefer those interested in social change. Competitive salary, fringe benefits and faculty appointment to medical school for qualified physicians. Please contact DR. HALE COOK, 3450 North 17th Street, Philadelphia, Pa. 19140.

SITUATION WANTED

Situation Wanted — Board-eligible obstetrician-gynecologist interested in partnership or association. Write Department 529, PENNSYLVANIA MEDICINE.

PRACTICES AVAILABLE

Practice Available—Office available (to rent) and equipment for sale due to death of physician. Please contact MRS. J. GUY SMITH, 1330 Susquehanna Avenue, Sunbury, Pa. 17801.

PHYSICIAN PLACEMENT SERVICE

SITUATIONS WANTED

Pediatrics—Several board certified or board eligible pediatricians seeking opportunities to practice in areas of need. Types of practice and locations preferred vary. Names and addresses on request from PHYSICIAN PLACEMENT SERVICE, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Pathologists—Board certified or board eligible seek place to practice. Only limited number listed. Contact PHYSICIAN PLACEMENT SERVICE, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Obstetrics and Gynecology—Eight M.D.s board certified or board eligible in OB-GYN seek immediate placement in Pennsylvania. Types of practices and locations preferred vary. For complete listing contact PHYSICIAN PLACEMENT SERVICE, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Surgeons—Some board certified, others board eligible, seeking opportunities to practice general surgery, neurosurgery, orthopedic surgery, thoracic cardiovascular surgery in solo, partnership, group, etc. List on request from PHYSICIAN PLACEMENT SERVICE, Taylor By-

pass and Erford Road, Lemoyne, Pennsylvania 17043.

Internists—Board certified or board eligible, seek opportunities in solo, partnership, group practices. For complete listing contact PHYSICIAN PLACEMENT SERVICE, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Pennsylvania Medical Society offers assistance through its Placement Service for physicians seeking locations as well as communities seeking additional medical coverage. There are registrations in most specialties and general practice. List of physicians in various specialties available on request. Communities seeking general practitioners are requested to list with the Service.

For further information, contact Physician Placement Service, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.



PMS—Serving You and Your Patient

Dear Doctor,

"How does the Medical Society and organized medicine serve you and your patient?" At all times, the Pennsylvania Medical Society represents the physician in legislative and governmental matters concerning Medicine on a State and National level. There is a constant public relations service on both levels to enhance the status of the profession and its individual members.

The State Society maintains the Medical Defense Fund for expenses involved in suits for alleged malpractice. The PMS Medical Benevolence Fund is maintained for the relief of members and families in financial distress. The PMS also maintains an Educational Fund to assist qualified members of your family. The PMS Physicians' Placement Service is ever present to assist members who wish to relocate in a new area. The Society constantly works with prepayment insurance plans to achieve equitable fees and policies. The State Society maintains a complete library service in connection with the Hershey Medical Center Library. Regional post-graduate sessions are a continuing program available to members.

As mentioned before, PMS also serves your patients by supporting legislation beneficial to the health and well being of the public—the mass immunization program being a prime example. It provides educational material on current medical and socio-economic subjects to the pa-

tient. It tends to promote good health and hygiene via newspapers, radio and television. The PMS constantly works with other professional groups to insure high standards of health care. Films on medical student recruitment and the public relations aspects of Medicine are always available. The PMS and County Society supplies speakers on all topics related to medicine.

Last but not least, the Society implements procedures to provide quality medical care at the lowest practical cost, and finally, as past-president of the Medical Society, J. Everett McClenahan, M.D., stated

"Don't ever be fooled that anyone in medicine, whether he is in practice or full-time teaching, is not very much a part of the entire field of medicine. Regardless of what you may think, you owe your prestige as a physician, which the community has bestowed on you, to the very organization you feel you shouldn't be a part of. . .

"If you feel strongly enough about your convictions, then there is an area (the Pennsylvania Medical Society) in which you may express yourself and be heard—and you should be."

LUSCIAN W. DILEO, M.D.
Bethlehem

*Reprinted from the Lehigh County
Medical Society Bulletin*

Advertiser's Index

Abbott Laboratories	28, 29, 30, 75, 76, 77, 78, 3rd Cover	Mead Johnson Laboratories	24, 25, 26
Breon Laboratories	47	Medical Protective Co.	47
The Brown Pharmaceutical Co.	43	Pennsylvania Hospital	69, 70
Burroughs-Wellcome	22	Pennsylvania Medical Golfing Association	36
Campbell Soup Company	59	Pitman-Moore	23
Dorsey Laboratories	39, 40, 41, 42	Poythress, Wm. P. & Co., Inc.	10
Geigy Pharmaceuticals	17, 18, 19, 20, 21, 32, 33	Robins, A. H. Co., Inc.	9
Glenbrook Laboratories	64	Roche Laboratories	38, 4th Cover
Hynson, Westcott & Dunning	1	Searle, G. D. & Co.	60, 61
Jefferson Medical College	8	Strasenburgh Laboratories	66
Lederle Laboratories	3, 11, 30, 34, 35, 70	The Stuart Company	65
Lehigh County Medical Society	13	Walker Corp. and Co., Inc.	14, 15
Lilly, Eli and Company	44, 45, 46, 48, 62, 63	Wyeth Laboratories	37

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

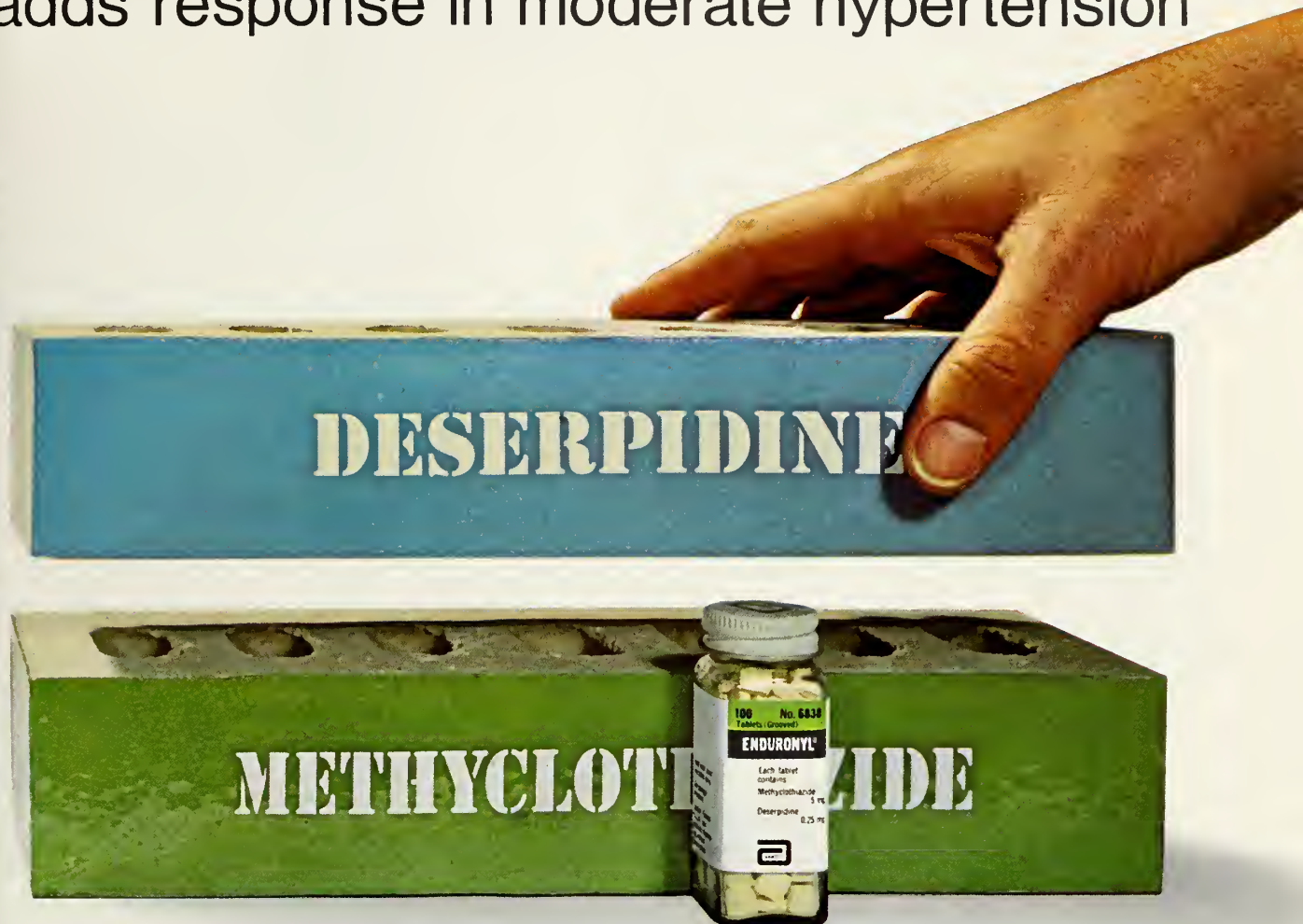
ENDURON

METHYCLOTHIAZIDE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

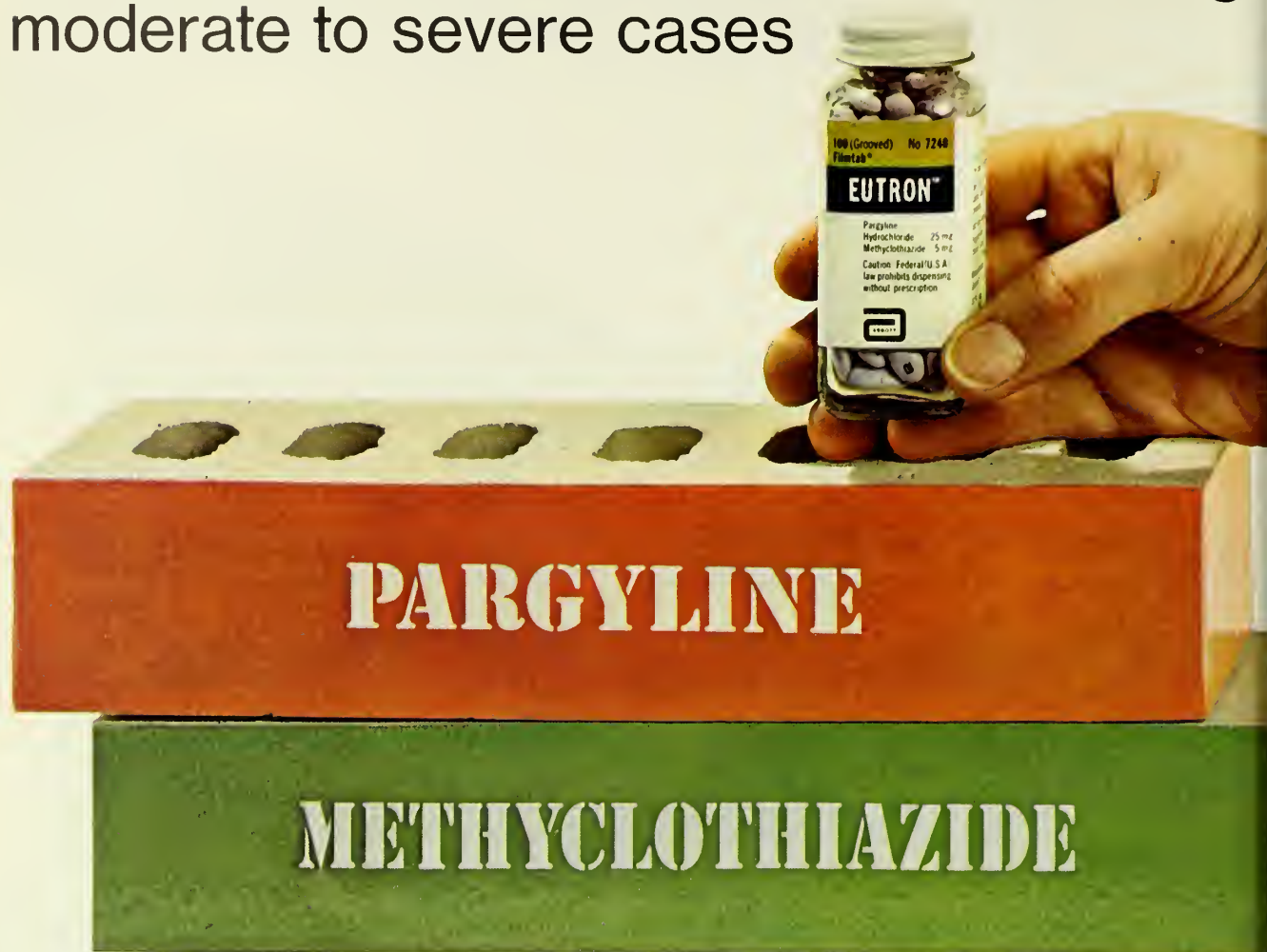
Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day
ENDURONYL®

METHYLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg. See Brief Summary on final page of advertisement



Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCHLOTHIAZIDE 5 mg.



See Brief Summary on final page of advertisement

801094

ENDURON[®] ENDURONYL[®]

METHYLOTHIAZIDE

Each tablet contains
Methylothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symptomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON[™] Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methylothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Phaeochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, deserpidine, nortriptyline or their analogues; other monoamine oxidase inhib-

itors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methylothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methylothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug.



804438R

Whenever anxiety induces or intensifies clinical symptoms

Librium[®]

(chlordiazepoxide HCl)

*Quickly relieves anxiety~Helps improve response in
psychophysiologic disorders~Seldom impairs
mental acuity or physical coordination, on proper dosage~
Has wide margin of safety*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing

gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly

and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs[™] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche[®]

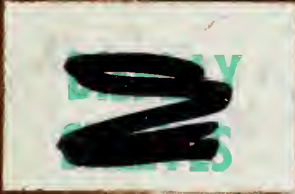
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Also available: Libritabs[™] (chlordiazepoxide) 5-mg, 10-mg, 25-mg tablets

PENNSYLVANIA MEDICINE

AUGUST 1968



DATELINE: VIETNAM

A Navy Physician Writes in the Battlefield
for "Pennsylvania Medicine"



51100 1000 1000
1000 1000 1000
1000 1000 1000
1000 1000 1000
1000 1000 1000

PENNSYLVANIA
MEDICAL
SOCIETY

OCTOBER
27-28-29
1968

COMMITTEE
ON
CONVENTION
PROGRAMS

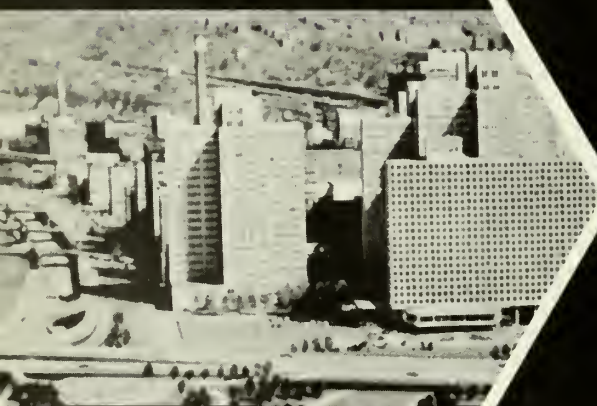
1968 *Scientific Seminars*

ELECTROLYTE
METABOLISM
AND
RENAL
DISEASES

CHATHAM
CENTER

PITTSBURGH

1968
TECHNICAL
EXHIBITS



RE-ELECTED TO AMA POST

Russell B. Roth, M.D., Erie, was re-elected without opposition to his post as Vice-Speaker of the AMA House of Delegates at the annual session of the AMA in San Francisco.

SCIENTIFIC SESSION PLANS FIRM

Plans have been completed for the PMS Scientific Seminar to be held in Chatham Center, Pittsburgh, October 27-29. Separated for the first time from the business meetings of the House of Delegates, the scientific meetings will concentrate on electrolyte metabolism and renal disease and will include a program for paramedical personnel and the public. The September issue of Pennsylvania Medicine will include a detailed program.

PMS ELECTION DAY

September 28, PMS Election Day, as part of the House of Delegates session in Pittsburgh beginning September 26, will include two positions on the Board of Trustees in addition to a President-Elect, four Vice-Presidents, a Secretary and a Speaker and Vice-Speaker for the House. The two elections to the Board of Trustees involve the fourth and fifth Councilor Districts where the respective incumbents, George A. Rowland, M.D., of Millville, and David S. Masland, M.D., of Carlisle, are eligible for re-election. Six delegates to the AMA and six alternate delegates will be elected, along with a member of the Committee to Nominate Delegates and Alternates to the AMA. There will be a vacancy on the Judicial Council and two vacancies on the Committee on Convention Program, the future of which is dependent on House action on a proposed Council on Education; which among other duties, would take over the responsibilities of the committee. District Censors from each component county medical society also will be elected.

NEW COUNCIL PROPOSED

A new Council on Education, under which all PMS activities in the graduate and post-graduate field would be grouped, is proposed for consideration by the PMS 1968 House of Delegates. The new council proposal was forwarded by the Board of Trustees which acted on a special study committee report. Should the new council be formed, the Committee on Convention Program would be dissolved.

BOARD TO CONSIDER BUDGET The next meeting of the PMS Board of Trustees will be held on the 14th of this month and will be preceded by Finance Committee meetings to consider 1969 budget proposals from the various councils, commissions and committees. Final action on the budget will be taken at the Board Meeting, September 25, in Pittsburgh and by the House in its sessions, September 26-28, in the Pittsburgh Hilton.

NEW ROLE FOR SPEAKER, VICE-SPEAKER The PMS House of Delegates in September will consider an amendment to the Constitution and ByLaws to make the Speaker and Vice-Speaker of the House of Delegates members of the Board of Trustees.

STATE DINNER EVENTS PLANNED Final plans are being made for a gala State Dinner on Saturday, September 28, as the one social event on the schedule of the annual business session in the Pittsburgh Hilton Hotel. Highlights of the evening will include the installation of George E. Farrar, Jr., M.D., Philadelphia, as the 119th President of the Pennsylvania Medical Society and the presentation of Past-President's medallion to John H. Harris, Sr., M.D., the outgoing 118th President of PMS.

COUNCILOR DISTRICT MEETINGS SCHEDULED Ten Councilor Districts have meetings scheduled on Thursday, September 26, from 3:00 p.m. to 5:00 p.m. at the Pittsburgh Hilton Hotel. The Councilor of each district extends a cordial invitation to all members of the county medical societies in his district to attend. At these meetings, there will be an opportunity to discuss matters of importance that will be brought before the House of Delegates, as well as to consider local problems. Meetings scheduled are as follows: Dist. 2-King's Garden Room; Dist. 3-Ballroom 1; Dist. 4-Trader's Room C; Dist. 5-King's Terrace; Dist. 6-Brigade G; Dist. 7-Black Diamond F; Dist. 8-Ballroom 3; Dist. 9-Brigade H; Dist. 11-Room 414; and Dist. 12-Room 709.

NEXT MONTH

WHY CONTINUING EDUCATION?

In a candid roundtable discussion, five members of the PMS Task Force on Continuing Medical Education review a multitude of approaches to one of the most vital problems facing Pennsylvania physicians today.

SHORT TERM TREATMENT OF ACUTE BURSITIS OF THE SHOULDER

In a double blind trial, response of patients treated with indomethacin was fair to good; patients who took a placebo receive little or no relief.

12 AUG 1968

References:

- (1) Siver, R. H.:
CMD, 21:109,
September 1954. (2)
Frykman, H. H.: Minn.
Med., 38:19-27,
January 1955. (3)
McGivney, J.: Tex.
State Jour. Med.,
51:16-18, January
1955. (4) Quehl,
T. M.: Jour. of Florida
Acad. Gen. Prac.,
15:15-16, October
1965. (5) Weekes,
D. J.: N.Y. State Jour.
Med., 58:2672-2673,
August 1958. (6)
Weekes, D. J.: EENT
Digest, 25:47-59,
December 1963. (7)
Abbott, P. L.: Jour.
Oral Surg., Anes., &
Hosp. Dental Serv.,
310-312, July 1961.
(8) Rapoport, L. and
Levine, W. I.: Oral
Surg., Oral Med. &
Oral Path., 20:591-593,
November 1965.

LACTINEX[®]

TABLETS & GRANULES

■ to help restore and stabilize
the intestinal flora

■ for fever blisters and canker
sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,^{1, 2, 3, 4} LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.^{5, 6, 7, 8}

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

**HYNSON, WESTCOTT
& DUNNING, INC.**



BALTIMORE, MARYLAND 21201

(LX04)



PENNSYLVANIA MEDICINE®

© 1968 Pennsylvania Medical Society

The Pennsylvania Medical Journal
Official Publication of the Pennsylvania Medical Society

AUGUST, 1968

VOLUME 71, NUMBER 8

FEATURES

Dateline: Vietnam	45
Cockroaches and Cherry Stones	60

NEWSFRONTS

Proposed Amendments to Constitution and By-Laws ..	7
Pennsylvanians in San Francisco	14
Professorship Honors Dr. Appel	16
Akron M.D. Wins Safety Award	21
Close-up/M.D.s	22
Capitol Report	34

EDITORIALS

No Ads	40
To Be or Not to Be	40

SCIENTIFIC REPORTS

Cardiovascular Briefs	54
Cancer Forum	59

GENERAL

Continuing Education	64
Obituaries	67
Meetings	68
Write Now	69
Classified	70
In My Opinion	73

Cover: Underground field hospital in Vietnam conceived by James Johnson, medical illustrator, York Hospital.

PUBLISHED MONTHLY BY THE
PENNSYLVANIA MEDICAL SOCIETY
TAYLOR BYPASS AND ERFORD ROAD,
LEMOYNE, PENNSYLVANIA 17043

Subscription \$5.00 Single Copy 50¢

PUBLICATION COMMITTEE

Joseph A. Walsh, M.D., Blakely-Olyphant
Chairman
D. George Bloom, M.D., Johnstown
H. Thompson Dale, M.D., State College
William J. Kelly, M.D., Pittsburgh
Robert S. Sanford, M.D., Mansfield

STAFF

Carl B. Lechner, M.D., 4111 Beech Avenue,
Erie 16508—Medical Editor
Thomas J. McCaghren, Taylor Bypass and
Erford Road, Lemoyne 17043—Man-
aging Editor
Claudia Helsel, Taylor Bypass and Er-
ford Road, Lemoyne 17043—Editorial
Assistant

CONTRIBUTING EDITORS

Harry E. Bacon, M.D., Philadelphia
William C. Beck, M.D., Sayre
Walter I. Buchert, M.D., Danville
Lewis T. Buckman, M.D., Wilkes-Barre
A. Reynolds Crane, M.D., Philadelphia
Garfield G. Duncan, M.D., Philadelphia
Mario N. Fabi, M.D., Scranton
George H. Fetterman, M.D., Pittsburgh
Wendell B. Gordon, M.D., Pittsburgh
Samuel B. Hadden, M.D., Philadelphia
Jack D. Myers, M.D., Pittsburgh
Thomas F. Nealon, Jr., M.D., Philadelphia
Eugene P. Pendergrass, M.D., Philadelphia
Mary DeWitt Pettit, M.D., Philadelphia
Sydney E. Sinclair, M.D., Camp Hill
David A. Smith, M.D., Harrisburg
James R. Watson, M.D., Pittsburgh

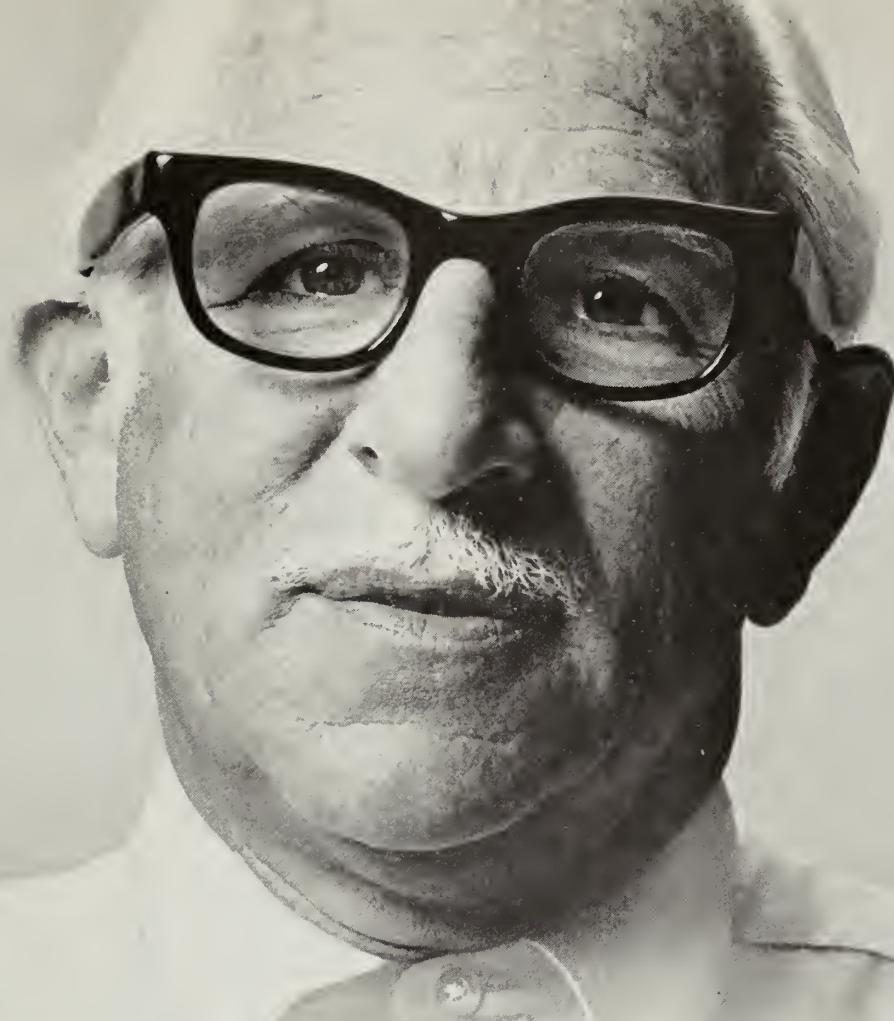
• **GENERAL.** Established 1897. Penn-
sylvania Medicine may not be held re-
sponsible for opinions expressed in any
of its contents.

• **EDITORIAL.** Address all original
papers, features, and editorial corre-
spondence to the Managing Editor.

• **ADVERTISING.** Pennsylvania Medi-
cine's advertising policy conforms with
principles governing advertising in
American Medical Association scientific
publications. National advertising rep-
resentatives: State Medical Journal Ad-
vertising Bureau, Inc., 510 North Dear-
born Street, Chicago, Illinois 60610.
Advertising rates on request to Penn-
sylvania Medicine office, Taylor Bypass
and Erford Road, Lemoyne, Pennsylvania
17043, or the SMJAB. For classified
rates, see classified section.

• **MAILING.** Second-class postage paid
at Lemoyne, Pennsylvania.

• **CHANGE OF ADDRESS.** Give name,
old address, new address (include ZIP
number), state if change is permanent
or temporary. Send notice to Pennsylv-
ania Medicine, Taylor Bypass and Er-
ford Road, Lemoyne, Pennsylvania
17043. Allow six weeks for change of
address.



He is elderly,
he is on corticosteroids,
when he needs an antibiotic
he may be a candidate for
DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of tatin is combined with demethylchlortetracycline in ECLOSTATIN.

or your susceptible candidates, prescribe DECLOSTATIN e broad-spectrum therapy that prevents monilial growth.

Indication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses indicated, and, if therapy is prolonged, serum level determinations be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may cause an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, phototoxic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Con-

stant observation is essential. If new infections appear, appropriate measures should be taken.

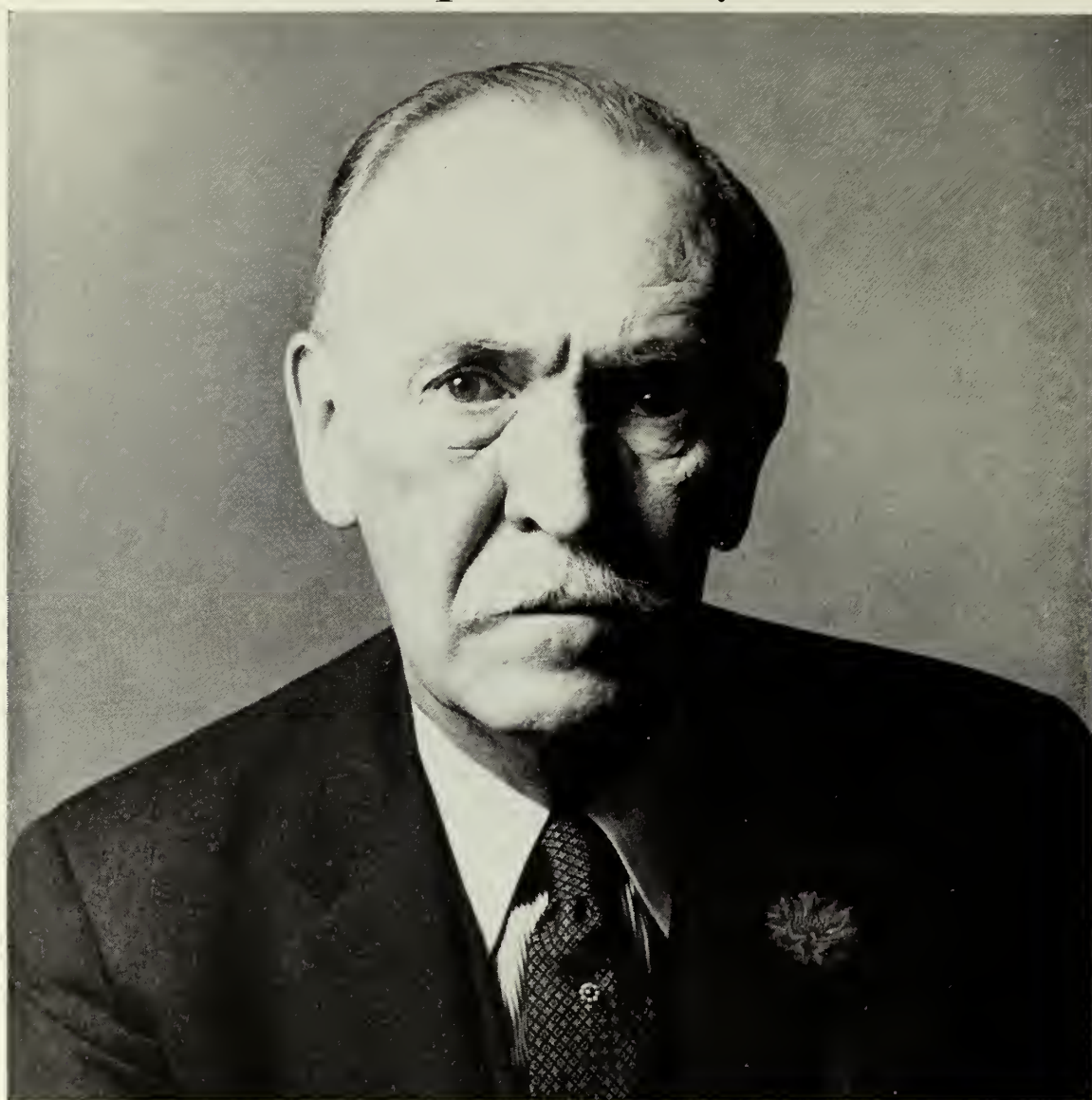
In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—*anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani.* Skin—*maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported.* Photosensitivity: *onycholysis and discoloration of the nails (rare).* Kidney—*rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare).* Hypersensitivity reactions—*urticaria, angioneurotic edema, anaphylaxis.* Teeth—*dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood.* Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

 Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Help the Needy!



A patient of advancing years may appear to “have everything,” but may well be in need—*medically*. You know the symptoms. He’s tired most of the time. Though there’s nothing wrong with him organically, he suffers from general malaise. Lassitude has become his way of life . . . vague aches and pains his major concern.

Such a patient has entered the “Mediatric Age”—that stage of his life in which he’s an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support he’s apt to need. MEDIATRIC is intended to help keep him more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition

to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal

bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

(Contains
15% alcohol†)
†Some Loss
Unavoidable

Mediatric® tablets • capsules • liquid

Steroid-nutritional compound



AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada

6838

21st Annual STATE DINNER

• Programme •

Reception

Dinner

Dancing and Entertainment

Installation of George E. Farrar, Jr., M.D.
as the 119th President of the Pennsylvania
Medical Society.

Presentation of Past President's Medallion to
John H. Harris, Sr., M.D., 118th President.



SATURDAY EVENING • SEPTEMBER 28, 1968 • HILTON HOTEL • PITTSBUR



Supplement to the Official Call to the Annual Session of the House of Delegates

In compliance with Article IX of the Constitution of the Pennsylvania Medical Society, the Board of Trustees and Councilors has nominated the following three qualified members of the Society for election to a five-year term on the Judicial Council:

Charles A. Bikle, M.D., Franklin County
Clarence J. McCullough, M.D., Washington County
John B. Montgomery, M.D., Philadelphia County

Proposed Amendments to the Constitution and By-laws

Printed below is the text of the amendments to the Constitution and By-laws as proposed by the Committee on Constitution and By-laws.

Note: Material which is underscored is being added. Material which is enclosed in [brackets] is being deleted.

I. Subject: Addition of the Speaker and Vice-Speaker of the House of Delegates to the Board of Trustees as ex-officio members with the right to vote; provision that the Speaker and Vice-Speaker shall preside over sessions of the House of Delegates, which function is not explicitly assigned to them at the present time.

CONSTITUTION

ARTICLE VIII—BOARD OF TRUSTEES AND COUNCILORS

Amend Section 2 as follows:

SECTION 2—COMPOSITION.

The Board of Trustees and Councilors shall consist of the President, the President-Elect, [and] the Immediate Past President [of this Society], the Speaker and the Vice-Speaker of the House of Delegates, ex-officio with the right to vote, and one Active or Senior Active Member from each Councilor District of this Society as determined by the By-laws. Each Trustee and Councilor shall be elected for a term of five years and shall serve until his successor shall have been elected and qualified. No trustee and Councilor shall serve more than two consecutive terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served more than two years, and for this purpose a year shall be deemed to be the period between annual sessions of the House of Delegates.

BY-LAWS

CHAPTER VI—OFFICERS

Insert a new Section 4, as follows:

SECTION 4—SPEAKER OF THE HOUSE OF DELEGATES.

The Speaker or the Vice-Speaker of the House of Delegates or a chairman delegated by the Speaker or the Vice-Speaker shall preside over all meetings of the House of Delegates. The Speaker of the House of Delegates shall in addition perform such other duties as may be required of him by the Constitution of this Society and these By-laws.

[Section 4] amended to become Section 5.
[Section 5] amended to become Section 6.
[Section 6] amended to become Section 7.
[Section 7] amended to become Section 8.
[Section 8] amended to become Section 9.

CHAPTER IX—ASSESSMENTS AND FUNDS

Paragraph 1 of Section 3 to be amended as follows:

SECTION 3—DEPOSIT OF MONIES AND SPECIAL FUNDS.

The Executive Director shall deposit all monies of the Society received by him in such bank accounts as the Treasurer shall direct and as shall be in accord with the provisions of Section [5] 6 of Chapter VI of these By-laws.

II. Subject: Establishment of a Council on Education to be responsible for all the Society's Educational Activities and under which the educational roles presently assigned to the Committee on Convention Program and the Council on Scientific Advancement would be consolidated; separation of the Annual Business Session of the House of Delegates and the annual scientific meetings which are linked together indirectly at the present time.

CONSTITUTION

ARTICLE VII—SESSIONS AND [MEETINGS] ASSEMBLIES

Add a new Section 4, as follows:

SECTION 4—SCIENTIFIC ASSEMBLIES.

Scientific assemblies of this Society may be held at such places and at such times as determined by the Board of Trustees and Councilors.

BY-LAWS

CHAPTER II—[MEETINGS]

GENERAL MEETINGS AND SCIENTIFIC ASSEMBLIES

Amend Section 1 as follows:

SECTION 1—[TYPES OF MEETINGS.] GENERAL MEETINGS.

[At the Annual Session there shall be two types of meetings: (a) general meetings and (b) scientific assemblies. At any special session of this Society there shall be a general meeting only. Registered members and guests may attend any such meetings.] The Annual Session of the Society and special sessions of the Society shall be presided over by the President or a Vice-President or a delegated chairman. The program at the Annual Session may include: (a) introduction of special guests and officers of the Society; (b) report on necrology; (c) installation of the incoming President and other officers; (d) any business within the jurisdiction of the membership; and (e) appropriate entertainment.

Amend Section 2 as follows:

SECTION 2—[GENERAL MEETINGS.] SCIENTIFIC ASSEMBLIES.

[A general meeting shall be presided over by the President, or a Vice-President, or a delegated chairman. The program may include: (a) introduction of special guests and officers of this society, (b) report on necrology, (c) installation of the incoming President and other officers, (d) any business within the jurisdiction of the membership, and (e) appropriate entertainment.] The Board of Trustees shall determine the scope and number of scientific assemblies and be responsible for the direction thereof. Scientific Assemblies shall be presided over by the Chairman of the Council on Education or a delegated substitute.

Amend Section 3 as follows:

SECTION 3—[SCIENTIFIC ASSEMBLIES.] REGISTRATION.

[A scientific assembly shall be presided over by the Chairman of the Committee on Convention Program or a delegated substitute.] No member or invited guest shall take part in any proceedings of the Annual Session or any special session or any scientific assembly unless he shall have first registered in the manner prescribed by the Executive Director.

Delete Section 4 as follows:

[SECTION 4—ADDRESSES, PAPERS AND DISCUSSION.

No address or paper before this Society, except those of the President and guests, shall occupy more than fifteen minutes without prior permission of the Committee on Convention Program. No member shall discuss any paper for longer than five minutes without unanimous consent. Each paper read before this Society shall be deposited with the presiding officer when read and shall become the property of this Society.]

Delete Section 5 as follows:

[SECTION 5—REGISTRATION.

No member shall take part in any of the proceedings of any Annual Session or any special session unless he shall have (a) registered on the registration blank provided by the Executive Director, and (b) been issued a badge or other evidence of registration, which shall not be issued by the Executive Director until his membership has been verified by the Official Roster of this Society.]

CHAPTER III—HOUSE OF DELEGATES

Amend Section 2 as follows:

SECTION 2—MEETINGS.

The House of Delegates shall meet on the day fixed by the Board of Trustees and Councilors as the first day of the Annual Session. It may adjourn from time to time as may be necessary to complete its business [provided that its hours shall conflict as little as possible with the scientific programs]. It shall also meet in special session at the time and place fixed by the Secretary as required by Article VII of the Constitution of this Society.

Paragraph 1 of Section 9 to be amended as follows:

SECTION 9—REFERENCE COMMITTEES.

The Reference Committees of the House of Delegates shall each consist of five members, whose terms shall end

the following May 31, appointed annually by the Speaker of the House of Delegates prior to August 1 from among the then certified voting delegates, and shall be as follows:

Committee on Reports of Officers
Committee on Reports of Standing and Special Committees
Committee on Scientific Advancement and Education
Committee on Governmental Relations
Committee on Public Service
Committee on Medical Service
Committee on Miscellaneous Business

CHAPTER IV—ELECTIONS

Section 5 to be amended as follows:

SECTION 5—NOMINATIONS.

All candidates for any office to be elected by the House of Delegates may be nominated from the floor except that candidates for the Board of Trustees and Councilors shall be nominated only by a delegate from the nominee's Councilor District. No nomination shall be accepted by the House unless the delegate making the nomination states that the nominee meets all of the qualifications prescribed by the Constitution and By-laws for the office. In addition to nominations from the floor, (a) candidates for delegates and alternates to the American Medical Association may and should be nominated by the Committee provided for in Section 2 [(h)] (f) of Chapter XIV of these By-laws, (b) a candidate for District Censor may and should be nominated by each Component Society, and (c) candidates for the Judicial Council [and the Committee on Convention Program] may and should be nominated by the Board of Trustees and Councilors.

CHAPTER VII—THE EXECUTIVE DIRECTOR

SECTION 1—DUTIES

Paragraph 2 to be amended as follows:

The Executive Director shall attend the meetings of the House of Delegates, the Board of Trustees and Councilors and the general meetings of this Society, and he shall be responsible for the preparation of the agenda of these meetings, and for the preparation of the program for [the] scientific assemblies [and sessions under the direction of the Committee on Convention Program or other appropriate committee].

CHAPTER IX—ASSESSMENT AND FUNDS

SECTION 6—MEDICAL DEFENSE FUND

First sentence of subsection (b) of paragraph 6 to be amended as follows:

(b) After approval of the member's application and determination that he has no insurance providing a defense to the action (or in cases of dispute as to coverage, pending such determination), the Committee of Counsel, composed as set forth in Section 2 [(e)] (c) of Chapter XIV of these By-laws, shall manage his defense.

CHAPTER XIV—COMMITTEES, ADMINISTRATIVE COUNCILS AND COMMISSIONS

SECTION 2—STANDING COMMITTEES

Paragraph 1 to be amended as follows:

This Society shall have the following standing committees:

Advisory Committee to the Woman's Auxiliary
 Committee on Constitution and By-laws
 [Committee on Convention Program]
 Committee of Counsel
 Committee on Medical Benevolence
 Committee on Aid to Education
 Committee to Nominate Delegates to the American Medical Association
 Committee on Objectives
 Committee on Relationships with Allied Professions
 Committee on Discipline

Subsection (c) to be deleted as follows:

[(c) Committee on Convention Program. The Committee on Convention Program shall consist of the President, the Chairman of the Finance Committee of the Board of Trustees, the Executive Director or his designated representative, and six members, two of which shall be elected each year by the House of Delegates. The chairman and vice-chairman shall be designated by the President and may not be appointed to succeed themselves. This Committee shall, subject to the instructions of the House of Delegates, determine the character and scope of the scientific proceedings and exhibits of this Society for each session and prepare a program for the Annual Session to be issued by the office of the Executive Director at least ninety days prior thereto.]

Subsection [(d)] amended to become subsection (c).
 Subsection [(e)] amended to become subsection (d).
 Subsection [(f)] amended to become subsection (e).
 Subsection [(g)] amended to become subsection (f).
 Subsection [(h)] amended to become subsection (g).
 Subsection [(i)] amended to become subsection (h).
 Subsection [(j)] amended to become subsection (i).

SECTION 4—ADMINISTRATIVE COUNCILS

Paragraph 1 to be amended as follows:

The administrative councils shall conduct all of the activities and business of the Society, except as otherwise provided in the Constitution and By-laws. The [four] five administrative councils shall be as follows:

(a) The Council on Education, whose membership shall consist of representatives of medical schools, hospital directors of medical education and practicing physicians, which shall be responsible for

(i) The coordination, evaluation, and long-range planning of continuing medical education.

(ii) Liaison with Pennsylvania medical schools, hospital directors of medical education, and health agencies for the purpose of furthering the Council's educational goals.

(iii) Organization and direction of scientific assemblies and other scientific programs as appropriate.

(iv) Liaison with paramedical groups in order to promote their continuing education.

Subsection [(a)] amended to become subsection (b).
 Subsection [(b)] amended to become subsection (c).
 Subsection [(c)] amended to become subsection (d).

Subsection (d) amended as follows:

AUGUST, 1968

[(d)] (e) The Council on Scientific Advancement which shall be responsible for all matters relating to the [extension of medical knowledge and the] advancement of medical science.

III. Subject: Provision of a reminder that effective dates should be considered in connection with membership amendments in the future.

CONSTITUTION

ARTICLE XV—AMENDMENTS

Article XV to be amended as follows:

ARTICLE XV—AMENDMENTS.

The House of Delegates may amend this Constitution at any session by an affirmative vote of two-thirds of the delegates present provided the text of the proposed amendment has been (a) submitted not less than four months, and not more than fifteen months, prior thereto, to a session of the House of Delegates, or to the Secretary of this Society by (i) the Committee on Constitution and By-laws, if the By-laws provide for such committee, or (ii) fifteen Active and/or Senior Active Members of this Society, whose signatures shall be appended thereto, and (b) at least two months prior thereto, published in the Journal of this Society, if there be such, and in the call for the session. The House of Delegates may determine the effective date of any amendment.

BY-LAWS

CHAPTER XVII—AMENDMENTS

Paragraph 1 to be amended as follows:

CHAPTER XVII—AMENDMENTS.

These By-laws may be amended at any Annual Session of the House of Delegates by an affirmative vote of three-fourths of the delegates present after lying over one day. If there be a majority but less than a three-fourths favorable vote, the amendment shall lie over until the next session of the House of Delegates and the adoption thereof shall be in the manner and in accordance with the procedure for amendments to the Constitution. The House of Delegates may determine the effective date of any amendment.

IV. Subject: Explicit provision for the right to speak before reference committees.

BY-LAWS

CHAPTER III—HOUSE OF DELEGATES

SECTION 9—REFERENCE COMMITTEES

Amend paragraph 2 as follows:

In addition to the foregoing, the standing Committee on Constitution and By-laws shall be a Reference Committee of the House of Delegates. Each member of this Society has the right to appear and be heard before any reference committee of the House of Delegates.

This supplement to the Official Call to the Annual Session of the House of Delegates has been issued this 17th day of June, 1968.

Allen W. Cowley, M.D., Secretary

Do you have patients who try to hide anger behind charm?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you.

Whether depression is open or secretive, Aventyl HCl assists in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.

800321



Eli Lilly and Company, Indianapolis, Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline Hydrochloride

(See last page for prescribing information.)





Aventyl® HCl

Nortriptyline Hydrochloride

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two months after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy.

The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl® HCl (nortriptyline hydrochloride, Lilly) under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized.

The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily

10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily

10 mg.—Ages three to six, 1 Pulvule one to three times daily

Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily

Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500.

[101267A]

Additional information available to physicians upon request.

800322



Eli Lilly and Company
Indianapolis, Indiana 46206



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

Announcing the blood chemistries anyone in your office can do. Those using Diagnostest* reagents and instruments. We train your nurse or medical assistant to use this simple, accurate system. For measuring hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. You get results in minutes. And the system includes everything you need. Write today for full information.

* trademark of The Dow Chemical Company





newsfronts



The Pennsylvania Delegation to the 1968 American Medical Association convention in San Francisco—left to right (Front): John S. Donaldson, Jr., M.D., Pittsburgh; W. Benson Harer, M.D., Upper Darby; M. Louise C. Gloeckner, M.D., Conshocken; Thomas W. McCreary, M.D., Rochester; Edward Lyon, Jr., M.D., Williamsport and Wendell B. Gordon, M.D., Pittsburgh. (Rear): William A. Limberger,

M.D., West Chester; Park M. Horton, M.D., New Milford; Edmund L. Housel, M.D., Philadelphia (an alternate delegate seated in the absence of Gilson Colby Engel, M.D., Philadelphia, who was participating in scientific sessions); Samuel B. Hadden, M.D., Philadelphia, and William B. West, M.D., Huntingdon.

Pennsylvanians in San Francisco

*Commonwealth physicians deemed most active, influential at the
AMA's Annual Convention in the Golden Gate city*

Pennsylvania's involvement and influence on the Annual Convention of the American Medical Association in San Francisco June 16-20 undoubtedly was greater than that of any other state.

From the opening gavel to adjournment, Russell B. Roth, M.D., of Erie, Vice Speaker of the AMA House, presided the majority of the time and—without opposition—was unanimously re-elected Vice Speaker.

One of the nine reference committees was chaired by a Pennsylvanian, Wendell B. Gordon, M.D., of Pittsburgh, and the Vice Chairman of the Pennsylvania Delegation, W. Benson

Harer, M.D., of Upper Darby, was a member of a second reference committee.

In reference committees and sessions of the House, two Pennsylvania past presidents of the AMA—James Z. Appel, M.D., of Lancaster, and Edward L. Bortz, M.D., of Philadelphia—actively presented information and guidance and were consulted frequently on the many items to come before members of the House of Delegates.

The highest court of American medicine—the AMA Judicial Council—was chaired by Elmer G. Shelley, M.D., of North East, Pennsylvania, who was prominently involved in a

series of important activities throughout the session, including Judicial Council action on a new definition of death to meet vital organ transplantation requirements.

Gilson Colby Engel, M.D., of Philadelphia, as a member of the AMA Council on Scientific Assembly, was vitally involved in the day by day operations of the Scientific Sessions and a variety of Pennsylvanians made scientific presentations and presented scientific exhibits.

William A. Sodeman, M.D., of Rosemont, was busy throughout the session as a member of the AMA Council on Medical Education.



View of a portion of the room at a Pennsylvania Delegation breakfast caucus at the AMA session in San Francisco. Clockwise, from 7 o'clock, Park M. Horton, M.D., of New Milford; John H. Harris, Sr., M.D., of Harrisburg, PMS President; Wendell B. Gordon, M.D., of Pittsburgh; Malcolm W. Miller, M.D., of Philadelphia; William A. Limberger, M.D., of West Chester; Robert F. Beckley, M.D., of Lock Haven, and PaMPAC Executive Director Eugene Zimmerman, of Harrisburg.



Participants listen intently to a report at a Pennsylvania Delegation 7 a.m. breakfast caucus at the AMA session in San Francisco. Clockwise are John B. Lovette, M.D., of Johnstown, alternate delegate; Carl B. Lechner, M.D., of Erie, alternate delegate; George B. Rowland, M.D., of Millville, alternate delegate; William B. West, M.D., of Huntingdon, delegate; and James Z. Appel, M.D., of Lancaster, past president of the AMA.

Pennsylvania delegate M. Louise Gloeckner, M.D., of Conshohocken, the only woman member of the AMA House, was a participant in a Reference Committee hearing and actively supported a resolution aimed at giving the AMA disciplinary power to end any discrimination. In fact, all members of the Pennsylvania Medical Society "official family" participated in various reference committee hearings. President-Elect George E. Farrar, Jr., M.D., of Philadelphia, alternate delegate Raymond C. Grandon, M.D., of

Harrisburg and Edmund L. Housel, M.D., of Philadelphia, an alternate who was seated as a delegate because of Dr. Engel's scientific duties, were involved in reference committee discussions of insurance and medicare. Alternate delegate William A. Barrett, M.D., of Pittsburgh, and delegation secretary Edward Lyon, Jr., M.D., of Williamsport, participated in discussions concerning federal legislation and Dr. Lyon also served as a Teller in the House. Alternate Delegate Wilbur E. Flannery, M.D., of New Castle,

expressed his views before the reference committee concerned with medical education. Delegate William A. Limberger, M.D., of West Chester, and PMS President John H. Harris, Sr., M.D., of Harrisburg, spoke before the Reference Committee concerned with Hospital Affairs. Delegate Samuel B. Hadden, M.D., of Philadelphia and alternate delegate Carl B. Lechner, M.D., of Erie, participated in various discussions before the Reference Committee concerned with Scientific Matters and Public Health. Delegate Park



Another member of the Pa. Delegation to the AMA—delegation vice-chairman W. Benson Harer, M.D., of Upper Darby, second from left, serves as a member of an AMA reference committee in San Francisco. To his right is reference committee member John L. Beven, M.D., of Baton Rouge, La., and to his left is reference committee chairman Carroll Witten, M.D., of Louisville, Ky., representing the section of general practice, and reference committee member L. W. Swanson, M.D., of Mason City, Iowa.



Wendell B. Gordon, MD, of Pittsburgh, member of the Pennsylvania Delegation to the AMA session in San Francisco, presides as Chairman of an AMA reference committee.



Part of group at a Pennsylvania Delegation breakfast caucus at the AMA session in San Francisco. Around table in foreground, clockwise from 8 o'clock, are M. Louise C. Gloeckner; John S. Donaldson, Jr.; William A. Sodeman, M.D., of Rosemont, member of the AMA Council on Medical Education; Elmer G. Shelley, M.D., of North East, Chairman of the AMA Judicial Council; Edward Lyon, Jr.; W. Benson Harer; Thomas W. McCreary.



View of Pennsylvania Delegation breakfast caucus at AMA session in San Francisco. Around table in foreground, from 9 o'clock, are Wilbur E. Flannery, M.D., of New Castle, alternate delegate; George E. Farrar, Jr., M.D., of Philadelphia, PMS President-Elect; William A. Barrett, M.D., of Pittsburgh, alternate delegate; Raymond C. Grandon, M.D., of Harrisburg, alternate delegate; and Park M. Horton, M.D., of New Milford, delegate.

M. Horton, M.D., of New Milford, and alternate delegate Malcolm W. Miller, M.D., of Philadelphia, expressed Pennsylvania's viewpoints before the reference committee which considered reports from the AMA Board of Trustees.

Delegate John S. Donaldson, Jr., M.D., of Pittsburgh, and alternate delegates John B. Lovette, M.D., of Johnstown and George A. Rowland, M.D., of Millville, appeared before one of the two reference committees concerned with miscellaneous business and the other such reference committee heard views expressed by delegate

William B. West, M.D., of Huntingdon, and alternate delegate William Y. Rial, M.D., of Swarthmore.

Throughout the session, Pennsylvania Delegation Chairman, Thomas W. McCreary, M.D., of Rochester, was busy presiding at caucuses, appearing before reference committees, speaking from the floor of the House and the host of other duties that fall on a chairman. He made the brief speech nominating Dr. Roth to succeed himself as Vice Speaker of the House and on behalf of the Pennsylvania Delegation, seconded the nomination of Gerald D. Dorman, M.D.,

of New York City as President-Elect of the AMA.

Dr. Rial made a strong showing as an alternate delegate candidate for a vacancy on the AMA Council on Constitution and ByLaws, but was defeated by a delegate from Washington, Robert B. Hunter, M.D.

The Pennsylvania Delegation had introduced one resolution which called on the AMA to consider establishing a standard wearing place for the Emergency Medical Identification Symbol, but the reference committee report, which claimed this would be a near-impossibility to establish, was upheld by the House.

Endowed Professorship in Psychiatry Honors Doctor Appel at U. Pa.

An endowed professorship in psychiatry, named in honor of Dr. Kenneth E. Appel, emeritus professor and former department chairman, has been established at the University of Pennsylvania School of Medicine, it was announced by Dr. Gaylord P. Harnwell, university president. He also announced that Dr. Albert J. Stunkard, chairman and professor of psychiatry, has been named the first incumbent of the chair.

Funds to endow the Kenneth E. Appel Professorship were given by more than 300 friends and associates of

Dr. Appel, who served as chairman of psychiatry at Pennsylvania from 1953 until his retirement in 1962.

"The establishment of the Kenneth E. Appel chair is a tribute to an extraordinary man whose vision and energy had so much to do with many developments in psychiatry, both nationally and at the University of Pennsylvania," Dr. Harnwell said.

"The University is fortunate in having as a successor to Dr. Appel so distinguished a psychiatrist and teacher as Dr. Stunkard," he stated.

Lock Haven Wife Selected As AMA Official

Mrs. Robert F. Beckley of Lock Haven has been elected treasurer of the Women's Auxiliary to the American Medical Association.

Mrs. Beckley, who has previously served three terms as a regional president, is a state auxiliary delegate to the Pennsylvania health council, serving on the legislative committee and state chairman of the committee on public health.

Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids. **SPHENOID SINUS**—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB



Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. Sinutab *not only* provides an effective decongestant — to reduce mucosal engorgement and facilitate freer breathing — *and* an antihistamine — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, two analgesics for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA **SINUTAB**[®] FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab[®] with Codeine.* Each tablet contains 15 mg. ($\frac{1}{4}$ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab[®] Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

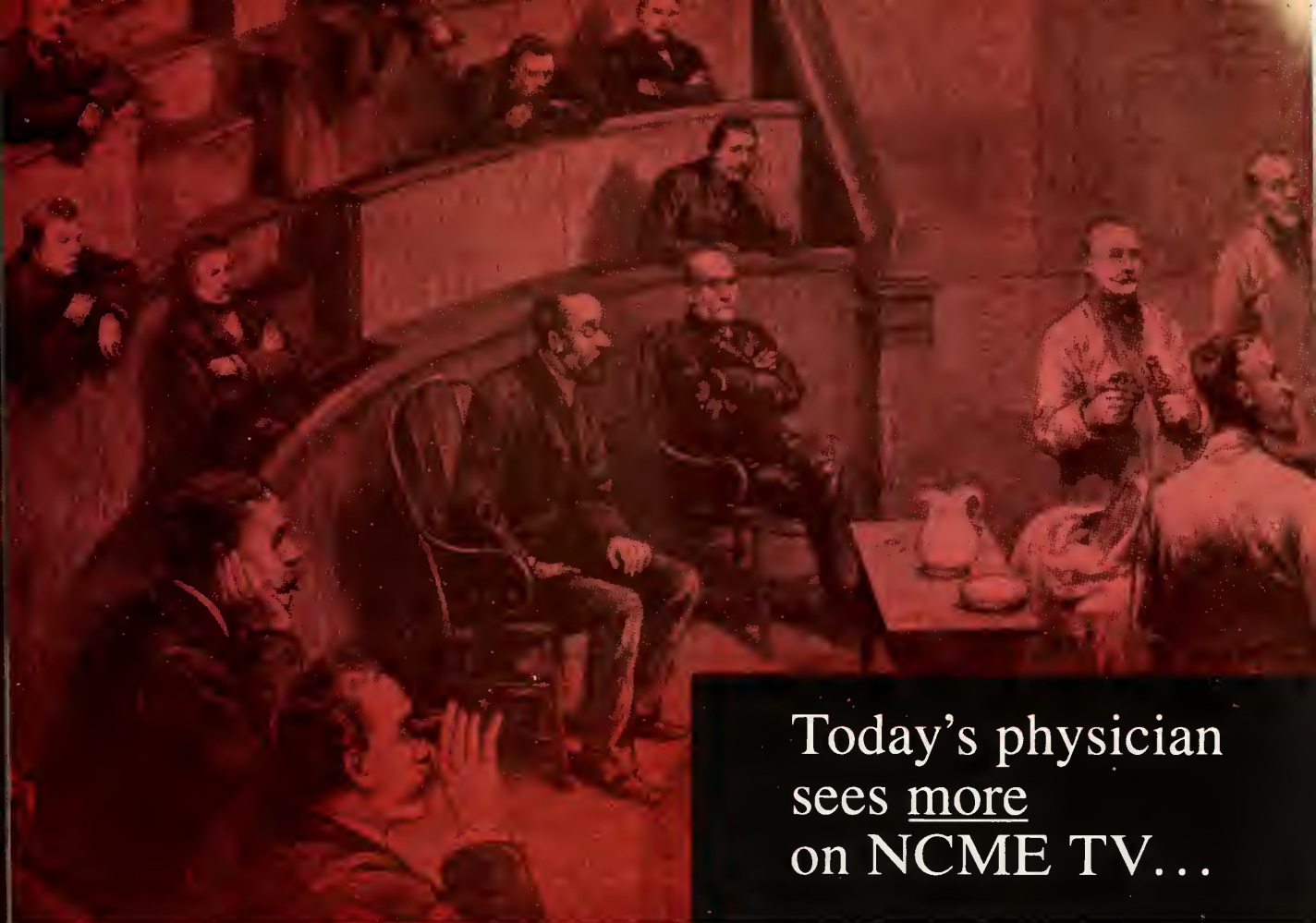
*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.



WARNER-CHILCOTT Morris Plains, N.J.

S-1N-81-4C



Today's physician sees more on NCME TV...

TMANN ARCHIVE

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME

The Network
for Continuing
Medical
Education

NCME TV Offers These Practical Benefits:

- ☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.
- ☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.
- ☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.
- ☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.
- ☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N. Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N. Y. 10017

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



newsfronts

Pitt Receives AMA Grant



The American Medical Association presented an allocation of \$9,496 to the University of Pittsburgh School of Medicine as part of the AMA's annual distribution of educational research funds.

Dr. Engene A. Conti, (left), President of Allegheny County Medical Society, presents the check to Francis S. Cheever, M.D., Vice Chancellor of the Health Professions and Dean of the Medical School at Pitt, in behalf of the AMA for the school's medical education programs.

The grant to Pitt was the third largest among the seven medical schools in Pennsylvania.

Child Health Conference Clinician Vacancies Open

The Secretary of Health, Commonwealth of Pennsylvania, has announced that there are three clinician vacancies available for Child Health Conferences in the state.

The vacancies are located in Orbisonia (Huntingdon Cty.), and Ralston and Unityville (Lycoming Cty.). The positions pay \$20.00 per clinic session (two hours). Depending on location, sessions might be held once or twice a week, or possibly twice a month.

There are also three vacancies in the Tuberculosis Program—clinic positions in Shamokin; Landis Hospital, Philadelphia, and Mercy Hospital, Pittsburgh.

Additional details concerning these vacancies may be obtained from John R. Clark, D.D.S., Staff Assistant for Program, Department of Health, Commonwealth of Pennsylvania, P. O. Box 90, Harrisburg, Pa. 17120.



Akron Physician Wins Auto Safety Award

A general practitioner in rural south-central Pennsylvania is the 1968-69 winner of the *Medical Tribune* Auto Safety Award, conferred annually since 1961 for "lifesaving achievement in the service of health."

The award has customarily honored individual physicians and organizations that have medical memberships or medically related safety programs.

This year's physician recipient is Edward J. Kowalewski, M.D., of Akron, Pa., who in 1960 launched a successful public campaign for the installation of a median barrier along the entire Pennsylvania Turnpike and in succeeding years saw its dramatic results in the decline of fatal head-on "crossover" collisions.

Dr. Kowalewski's concern for auto safety began, like that of so many physicians, with his grim personal involvement in the horrors of roadside accident medicine. It was ultimately the death of six persons, including three small children, in a fiery crash caused by a vehicle hurtling across the median strip that brought tragic support to Dr. Kowalewski's crusade and led to state action.

He had hounded officials of the Pennsylvania Turnpike Commission (with copies of his communications to the Governor and newspapers), pointing out that a median barrier would at least check the "crossover" carnage; turnpike authorities had replied that they thought a barrier might increase accidents.

Dr. Kowalewski asked for a hearing by the commission: this was finally held in Harrisburg after the six-death crash had persuaded officials to build a barrier on a 100-mile stretch of the highway. The doctor obtained letters of support from the American Medical Association and the Pennsylvania Medical Society, as well as from many individuals, including other physicians, Local newspapers published articles and editorials backing his stand. Finally, by 1964, the entire turnpike from Ohio to New Jersey was equipped with the median barrier.

The Pennsylvania Turnpike, said *Traffic Safety* magazine "enjoyed the safest year in its quarter century of operation in 1965, the first full year after it completed a 359-mile steel median barrier. . . In 1962, when construction of the safety barrier began, the pike's fatality rate per 100 million vehicle miles was 3.7. In 1965 it had dropped about 60 percent to the record low of 1.5."

Reprinted from Medical Tribune, June 17, 1968.

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60



anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.)
Against constipation. Now isn't that a good idea in an iron-containing hematinic?



LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R-6064



close-up/MD's

The following Pennsylvania physicians have been elected to membership in the American Academy of General Practice: **Arthur G. Deininger, M.D.**, Meadville; **Robert W. Hartnett, M.D.**, Johnstown; and **Matthew M. Brown, M.D.**, Sharon.

Robert Varner, M.D., Rimersburg, has been appointed administrator for the Rimersburg Medical Center, to fill the post vacated by **D. M. Briceland, M.D.**, deceased.

Kenneth L. Benfer, M.D., York, is the recipient of an honorary Doctor of Science degree, conferred by Albright College, Reading.

A. W. Cowley, M.D., Camp Hill, was presented an award for twenty-five years of service to Polyclinic Hospital, Harrisburg in ceremonies at the Hospital's Medical Day Program.

Wesley D. Stick, M.D., York, has been elected president of the Central Pennsylvania Chapter of the American College of Surgeons. Dr. Stick is a member of the medical staff at York Hospital.

Stephen Wartella, M.D., Kingston, has been elected president of the Lehigh Valley Medical Association. Other new officers are **Richard Ward, M.D.**, Bethlehem, first vice president; **Frank Runyeon, M.D.**, Reading, second vice president; **Jesse Hafer, M.D.**, Pottstown, third vice president; **Frank J. DiLeo, M.D.**, Allentown, fourth vice president; **Willard C. Masonheimer, M.D.**, Allentown, treasurer; and **Harold R. Weidaw, M.D.**, Tamaqua, secretary.

H. Ford Clark, M.D., Huntingdon, has been named president-elect of the Pennsylvania Academy of Ophthalmology and Otolaryngology. He is currently president of the Staff of the J. C. Blair Memorial Hospital.

Charles R. Druffner, M.D., Clark's Summit, has been certified by the American Board of Internal Medicine. He is a member of the medical staffs of Community Medical Center, Mercy Hospital, Moses Taylor Hospital and State General Hospital.

William J. Mitchell, M.D., presented a paper on athletic injuries at the 15th Annual Meeting of the American College of Sports Medicine at The Pennsylvania State University. Dr. Mitchell's topic was *Traumatic Neuropathy of the Peroneal Nerve in Athletes—Diagnosis and Treatment*.

Edward J. Notari, M.D., Scranton, has been elected president of the Lackawanna County Chapter, American Academy of General Practice. Dr. Notari is associated with the Lackawanna Medical Group.

Dorothy McClure Gilmore, M.D., Clearfield, has been chosen 1968 Woman of the Year by the Clearfield Business and Professional Women's Club. Dr. Gilmore is on the staff of Clearfield Hospital.

Lee S. Serfas, M.D., Easton, has been appointed director of surgery at Easton Hospital. Dr. Serfas will be responsible for the education of surgical residents and interns, for the continuing medical education of the attending staff and for the care of surgical patients.

William M. McKinley, M.D., has been accepted as a Fellow of the International Academy of Proctology. He is a diplomate of the National Board of Medical Examiners and a diplomate of the American Board of Surgery.

John L. Williams, M.D., director of the department of radiology at The Geisinger Medical Center, concluded his term as president of the Pennsylvania Radiological Society in May and was succeeded by **Roderick Tondreau, M.D.**, of Philadelphia.

Randolph C. Blodgett, M.D., **Roderick W. Cook, Jr., M.D.**, and **Frederick L. Jones, Jr., M.D.**, were the speakers at a forum dealing with quackery and arthritis held at The Geisinger Medical Center. Dr. Cook is chairman of the medical and scientific committee of the Central Pennsylvania Chapter of The Arthritis Foundation. Drs. Blodgett and Jones are members of the Medical Center's department of internal medicine.

Bernard L. Segal, M.D., clinical associate professor of medicine, Hahnemann Medical College and Hospital, represented The American College of Cardiology at the Interamerican Congress of Cardiology in Lima, Peru. He was moderator of a panel entitled, *Present Status of Auscultation and Phonocardiography*.

Karl H. Beyer, Jr., M.D., Senior Vice President for Research, Merck Sharp & Dohme Research Laboratories, West Point, was one of six prominent alumni to receive the University of Wisconsin Alumni Association's Distinguished Service Award. Dr. Beyer is a past president of the Federation of American Societies for Experimental Biology and is a member of the Drug Research Board of the National Academy of Sciences.

Martin L. Lee, M.D., an associate in the department of internal medicine at The Geisinger Medical Center, was program chairman for the 20th Annual Meeting of the Pennsylvania Allergy Association. The three-day program was held at the Allenberry Club, Boiling Springs. **Francis W. Davison, M.D.**, senior consultant in the department of otolaryngology and bronchoesophagology at The Geisinger Medical Center, was one of the guest speakers. His paper was titled, *Chronic Hyperplastic Rhinosinusitis: Diagnosis and Management*. **Harold Fisher, M.D.**, York, is president of the Association, **Leonard S. Girsh, M.D.**, Philadelphia, is president-elect, and **Benjamin G. Wood, M.D.**, Sharon, chaired the sessions.

Francis W. Davison, M.D., was elected president of the American Laryngological Association for 1968-1969, at the group's recent annual meeting. As president, he will conduct the annual meeting of the Association in New Orleans next March.

Dr. Davison is senior consultant in the department of otolaryngology at The Geisinger Medical Center. He was president of the American Bronchoesophagological Association in 1959 and president of the American Laryngological, Rhinological and Otological Society in 1966.

*Easy on
the Budget...*

*Easy on
the Mother*

*Tablets & Elixir
For Iron Deficiency Anemia*



BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS
Fergon[®]
brand of FERROUS GLUCONATE



Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

1913

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

EASTERN PENNSYLVANIA OFFICE:

E. L. Edwards, D. R. Lowe, L. R. Wilson, Jr., and S. B. Elston, Jr., Representatives
Suite 126-BC, The Benson, Jenkintown 19046 Telephone: 215-887-6335

WESTERN PENNSYLVANIA OFFICE: N. Wells and S. T. Ingram, Representatives

1074 Greentree Road, Pittsburgh 15220 Telephone: 412-531-4226

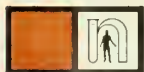


Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society
in recent months:

ALLEGHENY COUNTY:

RAYMOND L. COSS, JR., M.D., 316 Sunset Drive, Pittsburgh 15235.

MYRON FRIEDLANDER, M.D., 220 Meyran Avenue, Pittsburgh 15213.

BRADFORD COUNTY:

JOHN A. M. HINSMAN, JR., M.D., Robert Packer Hospital, Sayre 18840.

FREDERICK G. LEA, M.D., 323-D Hayden Street, Sayre 18840.

FREDERICK T. PERRY, M.D., 319-B Hayden Street, Sayre 18840.

BUCKS COUNTY:

RALPH E. SNYDER, M.D., R.D. No. 1, Stump Road, Pipersville 18947.

CARL HANSEN, M.D., Penn Ridge Medical Arts Bldg., Sellersville 18960.

CHESTER COUNTY:

GEORGE E. BENDER, M.D., 520 North Walnut Street, West Chester 19380.

CLINTON COUNTY:

CARL A. MEYER, JR., M.D., 353 Susquehanna Avenue, Lock Haven 17745.

DAUPHIN COUNTY:

EVAN G. PATTISHALL, JR., M.D., Hershey Medical Center, Hershey 17033.

DELAWARE COUNTY:

JOSEPH C. FLANAGAN, M.D., 39 Glendale Road, Upper Darby 19082.

ELK-CAMERON COUNTY:

SEBASTIAN LOMBARDO, M.D., Main Street, Kersey 15846.

MONTGOMERY COUNTY:

DONALD KOPP, M.D., 1133 High Street, Pottstown 19464.

PHILADELPHIA COUNTY:

ABRAM S. BENENSON, M. D., 1801 JFK Blvd., Philadelphia 19103.

PHILIP J. BYRNE, M.D., 4725 Griscom Street, Philadelphia 19124.

YORK COUNTY:

ROBERT M. DAVIS, M.D., B-11 Country Club Manor, York 17403.

JEFFREY D. HARE, M.D., 2471 South Queen Street, York 17402.



because relief means so much to your G.U. patient

There are not many drug combinations in use today which can claim to have served the medical profession for more than 50 years. Such a record reflects the continued confidence of physicians in URISED. This is not a dramatic "wonder drug" — but a useful one.

URISED is safe . . . especially useful in long-term management of chronic cases; as a prophylactic measure with catheterization or after instrumentation. No systemic reactions or bacterial resistance have been reported.

URISED rapidly exerts spasmolytic action, relieving pain and discomfort of urgency, frequency, and burning on urination. Rapid acting URISED exerts antibacterial action against uropathogens susceptible to methenamine and methylene blue, in an acid medium.

URISED®

Each blue-coated tablet contains active:

Atropine Sulfate . . . 0.03 mg.	Methylene Blue . . . 5.4 mg.
Hyoscyamine . . . 0.03 mg.	Phenyl Salicylate . 18.1 mg.
Methenamine . . . 40.8 mg.	Benzoic Acid 4.5 mg.

PRECAUTIONS: Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

SIDE EFFECTS: Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—Initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

Stocked Nationally Through All Service Wholesale Druggists



CONAL
PHARMACEUTICALS, INC.
CHICAGO, ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

• CYSTOSPAZ® • URISEDAMINE® • ŪTRASUL® Tablets and Suspension



Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnos-

tic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain

(water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

Pain Break" for an osteoarthritic. Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil[®] oxyphenbutazone

...a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. A rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis may occur suddenly in spite of regular, reported normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and tinnitus may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocyto-

penic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

**For complete details,
please see full
Prescribing Information.**

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. **Availability:** Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.



(B) 46-800-A

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TA-5306AR

MeadJohnson—pharmaceuticals created for your specialized clinical needs

A woman in a white wedding dress is shown from the waist up, holding a large bouquet of white flowers. She is looking down at the bouquet. In the background, another woman is holding a baby. The scene is set outdoors with a light-colored, textured ground.

She relies
on your
contraceptive
advice

She can expect to
continue Oracon for years

ORACON

16 White—Ethinyl Estradiol, 0.1 mg. Tablets. 5 Pink—Dimethi-
sterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control

program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral

contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some

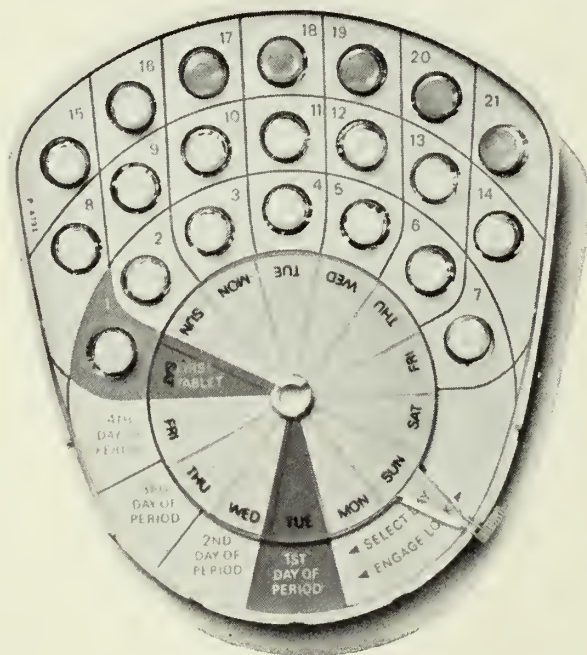
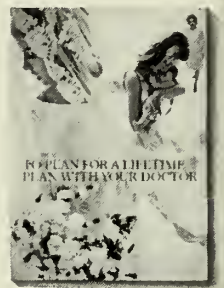
physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.

The Pakette® dispenser prevent patient error by showing her when to start her tablets and when to take every tablet all month long.



in the Pakette® dispenser

ORACON®

16 White—Ethinyl Estradiol, 0.1 mg. Tablets; 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Mead Johnson
LABORATORIES

PMS

OFFICIALLY
ENDORSED

DISABILITY INSURANCE PROGRAMS

ACCIDENT AND HEALTH PROTECTION

Indemnities up to \$250.00 per week. Long term sickness and lifetime accident protections available. Daily hospital benefits and surgical protection available for both members and dependents. Selection of waiting periods. Conversion plans available at age 70.

MAJOR HOSPITAL EXPENSE PROTECTION

\$7,500 Maximum Benefits after \$500 deductible for both members and dependents.
This protection may be retained *for life!*

HIGH LIMIT ACCIDENTAL DEATH, DISMEMBERMENT AND PERMANENT TOTAL DISABILITY

Maximum limit \$150,000 members; \$75,000 wife of member. New low cost of \$.85 per thousand per year. Full principal sum paid for permanent and total disability from bodily injury.

• BERTHOLON-ROWLAND AGENCIES •

WESTERN PENNSYLVANIA

Dexter Bertholon Rowland, Inc.

1518 Frick Building, Pittsburgh, Pa. 15219
471-9552
(area code 412)

EASTERN PENNSYLVANIA

Bertholon Rowland, Inc.

Public Ledger Bldg., Philadelphia, Pa. 19106
WAlnut 5-7045
(area code 215)

★ THE MAN WHO PLANS AHEAD INSURES WHILE HE IS INSURABLE ★

An anorectic will help her lose weight—
but can she keep it off?
You need more than a pill
(even ours) to do that!



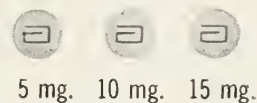
That's why Abbott offers
you a pill plus a program.



The Product

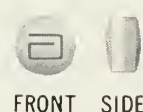
*For smooth appetite
control plus mood
elevation*

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

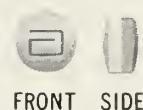


*For patients who can't
take plain amphetamine*

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



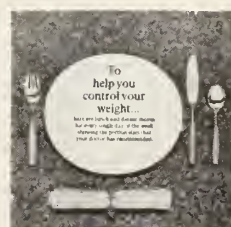
Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



801444

*See Brief Summary
next page.*

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444



PENNSYLVANIA
MEDICINE

capitol report

1968 CHECKLIST OF IMPORTANT LEGISLATIVE PROPOSALS AND ISSUES

PART II

LABORATORY ANIMAL LEGISLATION—is again being pushed by several of the pet owner organizations. These groups have succeeded in obtaining sponsorship of legislation by key members of Congress which, if passed, would give the Secretary of HEW, rather than the Secretary of Agriculture, authority to extend federal controls and licensure over the care and experimental use of laboratory animals. AMA opposes federal licensure of laboratory facilities.

HOUSE INTERSTATE COMMITTEE AND SENATE LABOR AND PUBLIC WELFARE COMMITTEE BILLS—extensions are necessary for many expiring programs and bills have been introduced by the administration. HR 15757 and S. 3095, Health and Manpower Act, extends the Health Professions Educational Assistance Act for four years and includes grants for construction of facilities, as well as dollars for education, improvement and student assistance. This bill groups with it the Allied Health Professional Personnel Training Act, the Graduate Public Health Training Act, and the Health Research Facility Construction Act. Another administration bill, HR 15758, extends for five years the Regional Medical Programs (heart, cancer and stroke), but it does not add construction funds. It also extends for two years a program of grants for health clinics for migratory workers and includes authorization for treatment of alcoholics and narcotic addicts in community mental health centers. The Senate bill contains only the Regional Medical Programs. Another administration bill, HR 15759 and S. 2944, provides for establishment of a U.S. Compendium of Drugs to be formulated by HEW and distributed to physicians, hospitals, etc., with the drug industry paying for the venture. Another proposal is the Health Personnel Act of 1968, establishing a new federal health personnel system to be known as the Health Service of the U.S. Other public laws which will need extension on which legislation has not yet been introduced include the Clean Air Act, the Motor Vehicle Air Pollution Control Act, and the Water Pollution Act.

SOCIAL SECURITY LEGISLATION—according to many Capitol experts, will be neglected in 1968. However, history suggests otherwise—there has always been a Social Security bill enacted in an election year, at least recently—that's politics. In such an event, it is likely that all the old problems will again be with us, such as chiropractic benefits, coverage of all of the disabled and many others under age 65, elimination of co-pay and deductibles, etc., and inclusion of drugs as a Medicare benefit as suggested in Senator Montoya's S. 2936 calling for reimbursement subject to a \$25 deductible and 20 percent co-insurance for drugs approved by a formulary committee.

the ^{In peptic ulcer:} antacid puzzle



solved by **Mylanta**[®]

aluminum and magnesium hydroxides plus simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta also contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients — after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.



Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor).....	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B ₁₂ activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.).....	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate).....	110	mg.
Ascorbic Acid (Vitamin C).....	75	mg.
Folic Acid.....	1	mg.

Indications: Trinsicon® (hematinic concentrate with Intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B₁₂ therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B₁₂ (parenteral or oral with potent Intrinsic factor as in Trinsicon® [hematinic concentrate with Intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B₁₂. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B₁₂, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic

You can treat combined
deficiencies with

Trinsicon[®]

—the multifactor hematinic



Vitamin B₁₂ plus intrinsic factor (15 mcg. B₁₂ activity)—helps provide adequate levels of this important vitamin.



Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.



Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.



Iron (110 mg.)—treats hypochromic anemia.

Clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon[®] (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500.

[032560]

Additional information
available to physicians
upon request.

Eli Lilly and Company,
Indianapolis, Indiana 46206.

801668

Lilly



choose an experienced candidate—
millions of doses prescribed

Benadryl[®]
(diphenhydramine hydrochloride)



The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals[®], containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

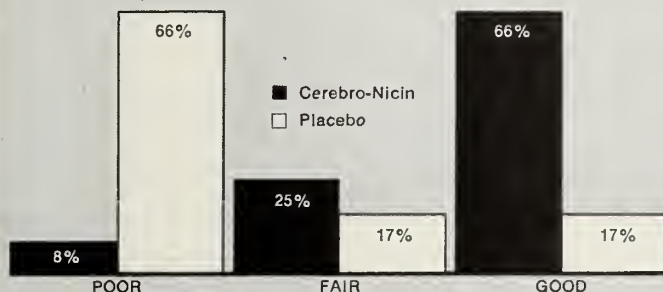
47968

For the treatment of the aging patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin[®] capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN[®] New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc., June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylentetrazole.....100 mg.
Nicotinic Acid.....100 mg.
Ascorbic Acid.....100 mg.
Thiamine HCl.....25 mg.
L-Glutamic Acid.....50 mg.
Niacinamide.....5 mg.
Riboflavin.....2 mg.
Pyridoxine.....3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylentetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.



Write for literature and samples...

BROWN

THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

Write for Product Catalog

in the treatment of
IMPOTENCE



Android[®]
(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID

GOOD TO EXCELLENT 75%

PLACEBO

20%

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths
Android

Android-HP
HIGH POTENCY

Android-X
EXTRA HIGH POTENCY

Android-Plus

Each yellow tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . . 10 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Each red tablet contains:
Methyl Testosterone . . . 5.0 mg.
Thyroid Ext. (1/2 gr.) . . . 30 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Each orange tablet contains:
Methyl Testosterone . . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Each white tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/4 gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . . . 250 mg.
Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate . . 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057



also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone 2.5 mg.
Ethynyl Estradiol 0.02 mg.
Thyroid Ext. (1/8 gr.) 10 mg.
Thiamine Hydrochloride 10 mg.
Glutamic Acid 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, postoperative and debilitated disease, osteoporosis. DOSE: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRAINDICATIONS: See Android. Ethynyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.



No Ads

Every month, as one of my editorial emoluments, a medical journal appears on my desk which is unique among its fellows. It is unique on two counts: it travels much farther than the others and it does me less good. Its failure to be of service lies in no defect of its own but in me . . . I cannot read Russian. Still, I am fascinated by its novelty and usually manage to learn the tenor of its articles by figuring out a word here and there, by studying the charts and illustrations . . . and by reading the summaries in English.

I strongly suspect that it is a highly scientific and valuable publication. But it has another feature which is even more distressing to me than my inability to read it. There are no ads! At first blush this might seem appealing, especially to those physicians who believe that they acquire all of their knowledge by perusing words and tables and illustrations and by immediately and methodically stacking the information in their memory banks.

As for me, the absence of advertising in my Russian journal has caused me to reconsider the place of advertising in continuing medical education and I think that it holds an important place. I think that the knowledge of the practitioner comes from a combination of hard study, experience, cursory study, casual exposure to information and ideas in the course of talking to doctors, nurses, detail men, pharmacist and many others. The intake from these sources is not neatly structured, at first, but has a changing and nebulous form, as it grows and shifts. I suspect that a number of fixed points in this body of knowledge come

from the repeated exposure to the kinds of information which come to the eye of the doctor as he scans the advertising in his medical journals. The beginning of therapeutic wisdom may lie in this brief but vivid exposure. Depths of wisdom, of course, demand deep study and reflection and experience as a sequel to this initial awareness. Only after such study is the arrangement orderly and fixed.

We practitioners are all indebted for this first increment of wisdom in treatment to those important members of our competitive free enterprise system, the pharmaceutical manufacturers. I am convinced that their contribution, their advertisements, their promotions, form an important, an integral part of our journals. I hope that we do not limit its freedom in the pursuit of truth in advertising to the extent that it is no longer the vivid first insight of knowledge. I hope that we do not see it regulated out of existence.

I am willing to take more of a chance with our country's physicians in this matter of acquiring therapeutic knowledge than is our Food and Drug Administration. This agency worries lest an overstatement or a misstatement creep into the advertising. They fear that an improper emphasis may be given to one feature or another in the story of a medication. I think that they undervalue my profession. A grain of salt is always in the doctor's eye as he scans the advertisements. He can be counted on to use these presentations for what they are—promotions of armaments from which he can select his weapons against his patient's ills.

CBL

To Be Or Not To Be

The 89th and 90th Congress passed many laws to redress real or imagined wrongs in the healthcare of this nation. The best health care is now the "legal" right of every last citizen. Thank your deity that most citizens don't know this or perhaps don't want this care.

Let's be realistic! How many of the 200,000,000 citizens of the U.S.A. can you keep well and cure or rehabilitate when they are ill? Of course, your efforts would eventually prevent illness. Do we turn to machines? Do we utilize persons less well-trained than physicians? Good medical care is an intimate and personal thing—*eyeball to eyeball*. You need to understand your patient who in turn needs to understand you in order to trust you. Are you smart enough to perform this function for your share of the total population?

Diagnosis depends on (a) facts—history, physical and laboratory findings; (b) a thorough knowledge of medical science; (c) the personality of the physician; and (d) the intuition derived from clinical experience. The first three of these can be programmed on a computer—"Are you all right, Jack?"

You and I know that the best service—medical, legal, business, etc.—is derived from the responsibility of a physician to his patient, a lawyer or an accountant to his client;

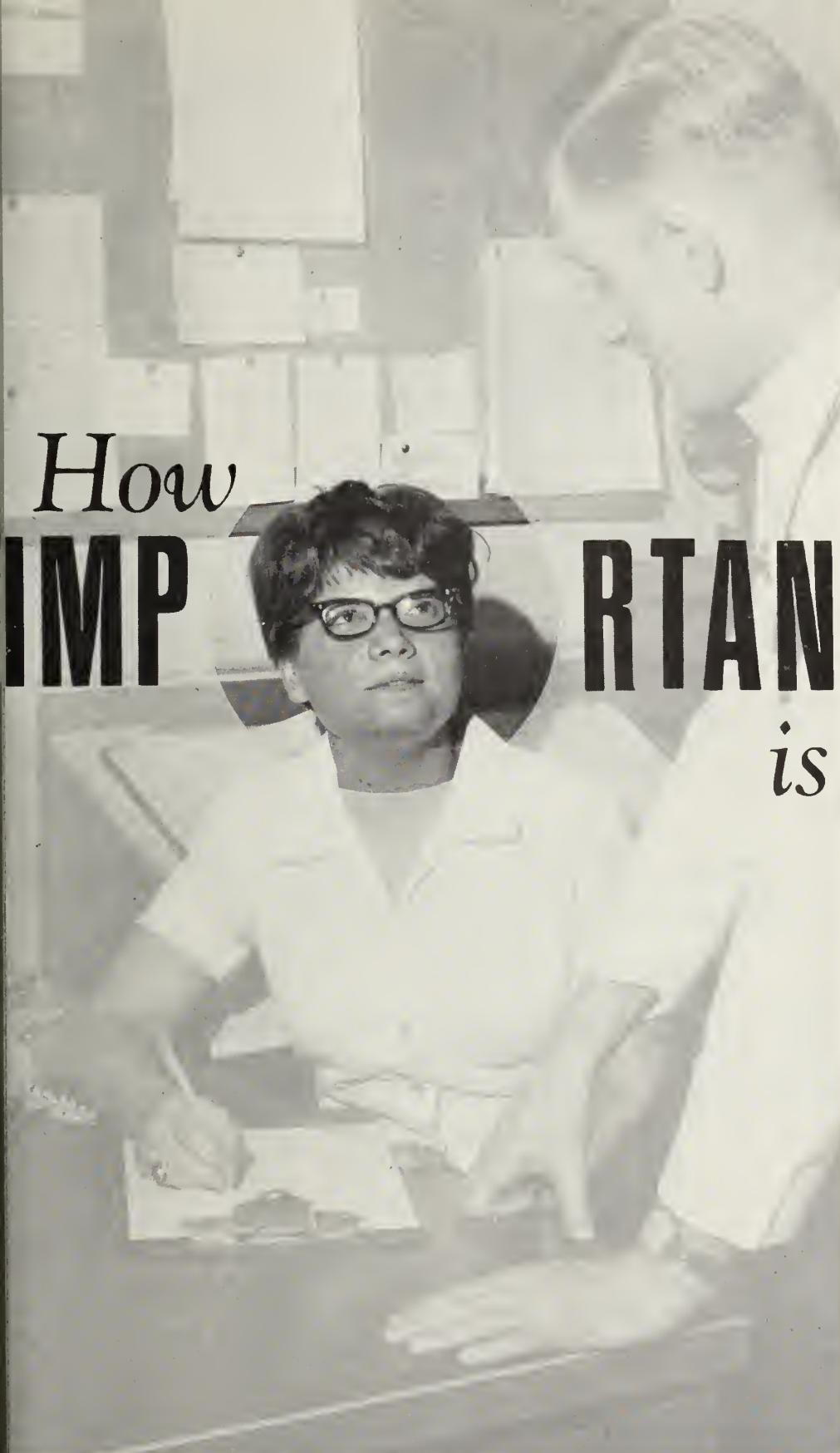
private practice it has been called. But the voters of this nation have asked for public, instead of private, accountability of us all—*doctors, lawyers, merchants, chiefs*.

Regional Medical Programs, Comprehensive State Health Planning, Mental Health and Mental Retardation Programs, Public Health Facilities, Hill-Burton Hospital Construction, Traffic Safety including Emergency Medical Care, Model Cities, Office of Economic Opportunity and other recent Public Laws are upon us. These are not problems for your Congressmen *only*, even though he voted for them. Remember, these were passed to redress real or imaginary wrongs.

It is questionable if even this affluent nation can afford full health services for all citizens with present methods of distribution of health care. Don't let a medically uninformed public destroy the excellent but limited health facilities, personnel and organizations which we have. As a privileged citizen, Doctor, you must become involved in the planning, the implementation, the extending, the policing of health care. Without physicians there can be no health care!

E pluribus unum.

GEORGE E. FARRAR, JR., M.D.
PMS President-Elect



Your
**MEDICAL
ASSISTANT**

How **IMP** **RTANT** *is she?*

When you think about all she does for you, she is almost like an extra set of hands! On top of all the things she now is doing, you can help her do a better, more efficient job. Encourage her to be active in the county, state and national Association of Medical Assistants.

Through her county Association of Medical Assistants and the Pennsylvania Association of Medical Assistants, your "Gal Friday" can pick-up valuable knowledge that will assist you and her in her everyday work at the office.

Give the Association of Medical Assistants your support . . . for the betterment of your extra set of hands!

OBJECTIVES OF THE ASSOCIATION of MEDICAL ASSISTANTS

To promote self-improvement of its members so that they can better serve the profession. ● To cooperate with the medical profession in improving its public relations. ● To inspire its members to render honest, loyal and efficient service to the profession and the public. ● To stimulate educational services for the betterment of its members.

For Further Information, Write: Pennsylvania Medical Society Council on Public Service

UNIVERSITY OF PENNSYLVANIA
DIVISION OF GRADUATE MEDICINE
SCHOOL OF MEDICINE

Presents a Course in

MEDICAL HYPNOSIS

BEGINNING SEPTEMBER 26, 1968

3:00 - 7:00 P.M., Thursdays

TUITION \$150

20 Weekly Afternoon Sessions

The course is open to all graduate physicians. It consists of lecture, demonstration, and supervised practical work in hypnosis totaling 80 hours.

For further information contact:

Office of the Director, Division of Graduate Medicine
237 Medical Laboratories
University of Pennsylvania
Philadelphia, Pa. 19104

THE INSTITUTE OF THE PENNSYLVANIA HOSPITAL
PRESENTS A COURSE IN

APPLIED OFFICE PSYCHIATRY

BEGINNING SEPTEMBER 26, 1968

3:00 - 7:00 P.M., Thursdays

12 Weekly Afternoon Sessions

TUITION \$50.00

This course is open to all graduate physicians and consists of lectures, demonstrations, and practical work on basic concepts and clinical application designed to give the maximum useful information to the practicing physician who is interested in improving his ability to manage the psychiatric problems commonly encountered in the practice of medicine.

For further information contact:

Sydney E. Pulver, M.D., Course Director
The Institute of the Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa., 19139

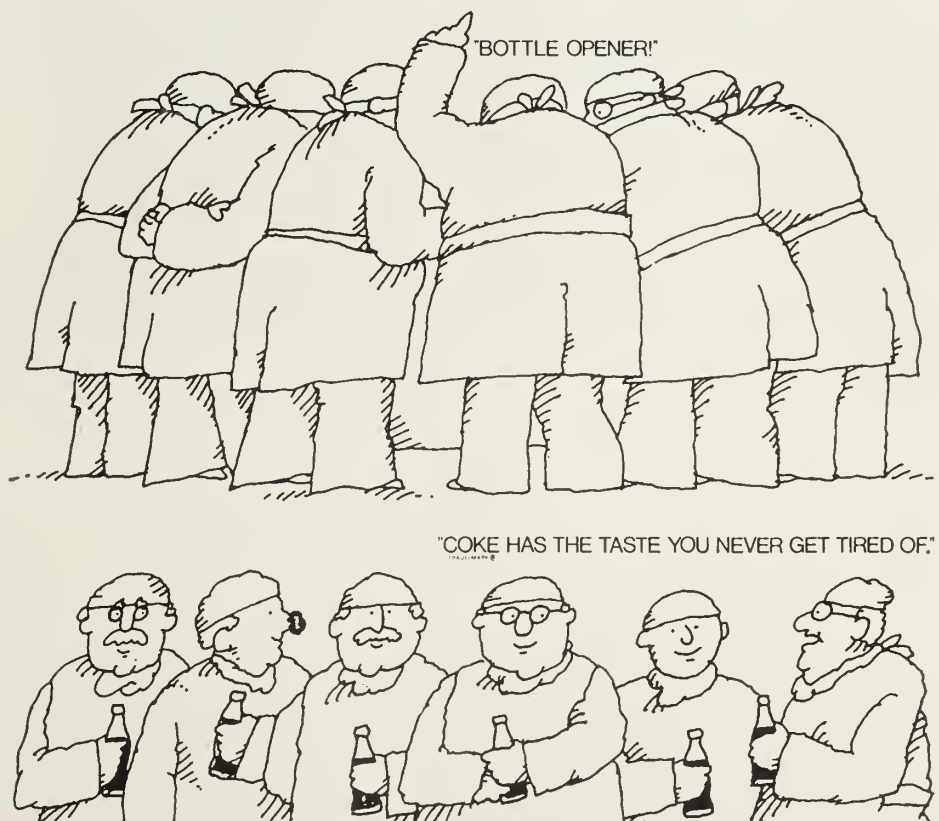
THE INSTITUTE OF THE PENNSYLVANIA HOSPITAL
PRESENTS A COURSE IN
MEDICINE AND THE LAW
BEGINNING OCTOBER 9, 1968

1:00-3:00 P.M., Wednesday
10 Weekly Afternoon Sessions
TUITION: \$50.00

This Course is open to all graduate physicians and consists of lectures and discussion on legal questions of vital interest to the practicing physician. Doctor Jonas Robitscher, practicing psychiatrist and lawyer, will conduct the course.

For further information contact:

Sydney E. Pulver, M.D., Course Director
The Institute of the Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pennsylvania 19139



"COCA COLA" AND "COKE" ARE REGISTERED TRADE MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA COLA COMPANY

Part of
the fine art
of medicine



DARVON[®] COMPOUND-65

Each Pulvule[®] contains 65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to
physicians upon request.
ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA 46206



800118



Surgical intensive care unit and recovery room at Phu Bai, Vietnam.

DATELINE: VIETNAM

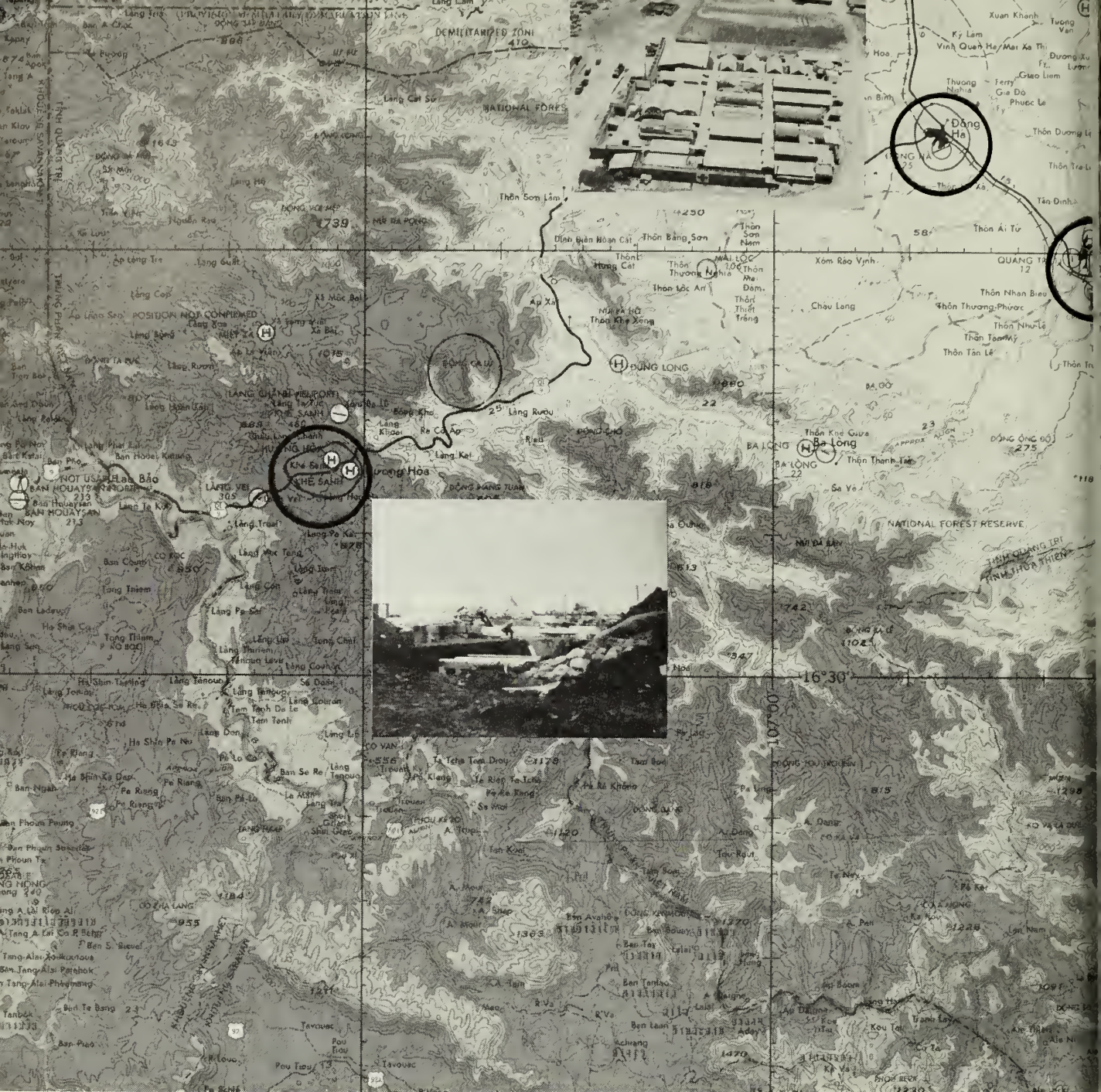
A front-line report on the practice of medicine in the battlefield as told exclusively to Pennsylvania Medicine by Commander Robert A. Brown (Medical Corps), U. S. Navy, of Frackville, on duty in Vietnam



Pennsylvania physicians operated in this typical Union field hospital near Gettysburg from August to November, 1863.

Military physicians treating the thirty thousand Union and Confederate soldiers wounded at Gettysburg in July 1863 were handicapped by the lack of medical supplies and facilities, and some by lack of training. Amputation and palliation were the treatment of necessity. Wounded often walked great distances to secure the inadequate medical aid available. Battlefield medicine has made great advances since that conflict, as evidenced by the medical treatment of American troops in Vietnam. Casualties do not walk to aid stations but are airlifted via helicopter to stationary medical facilities, usually not more than ten minutes away.

As in earlier wars, Pennsylvania physicians continue to serve as combat physicians. During the siege of Khe Sanh in the northwest sector of the Republic of Vietnam, three U. S. Navy medical officers were part of the medical team serving the Third Ma-



rine Division, Fleet Marine Force. Commander Robert A. Brown, a native of Frackville, served as Commanding Officer, and Lt. James Finnegan, Pittsburgh, and Lt. Joseph G. Cesare, Old Forge were attached to the unit as general medical officers.

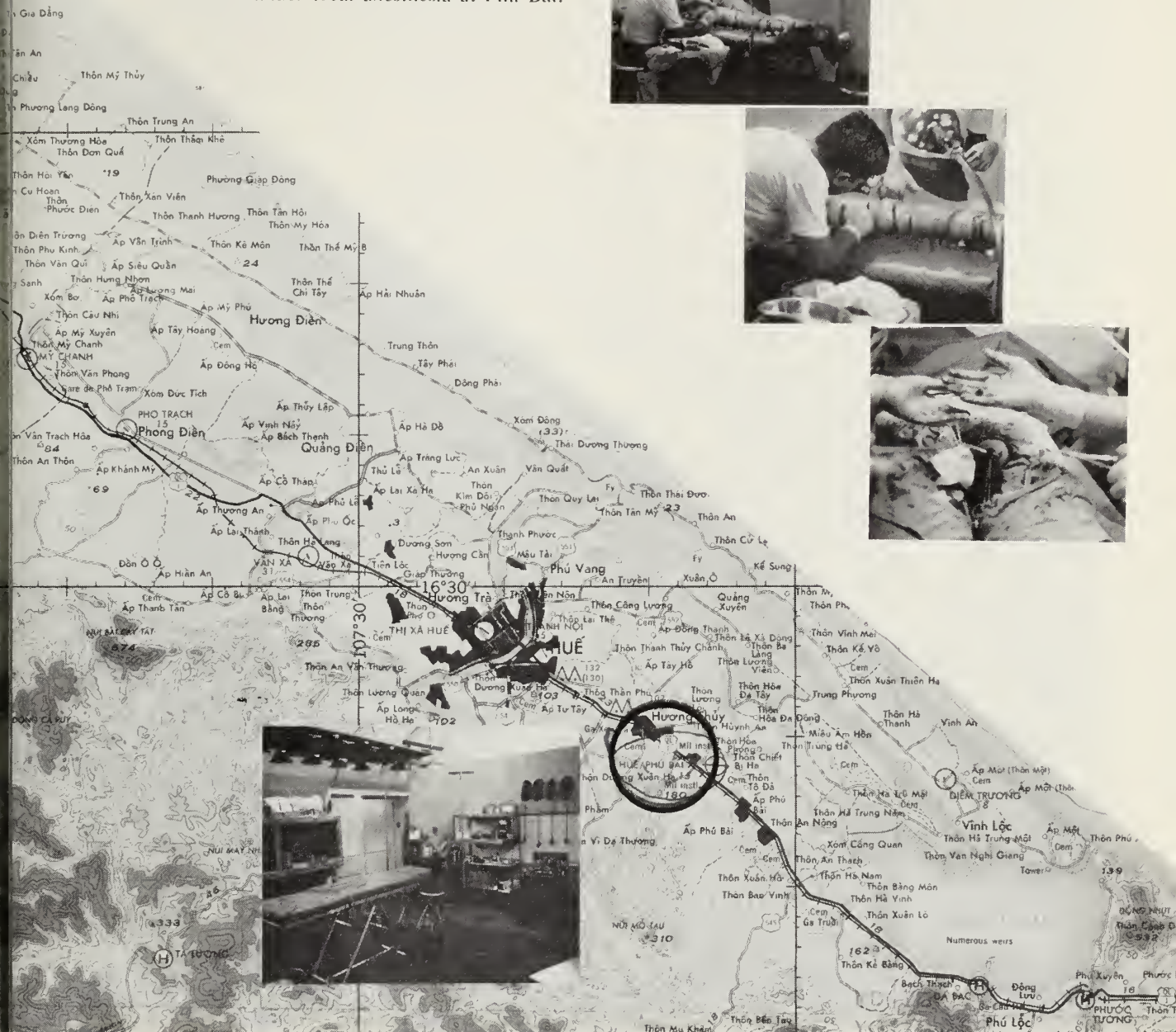
Physicians on duty with the Third Marine Division fall into three categories: the general medical officer (GMO), who usually has had no previous military training; the specialists, who may or may not have been trained in a military hospital; and the career senior officer who serves either as

Medical Battalion Commander or Division Surgeon.

Lt. Cesare, as a GMO, is assigned to the Division for a one year tour. Normally, he, like any other general duty physician, can anticipate a four month tour with the "grunts," usually in an infantry outfit. He almost always will be involved in one operation against the enemy. He is responsible to the line Battalion Commander for advice on the prevention and control of disease, the training of his corpsmen, and the initial care of the acute field casualty.

Like any other general medical officer, he adapts very rapidly to the smooth and rapid treatment of large numbers of casualties. He almost daily sees massive soft tissue trauma, with gross contamination caused by booby traps and mines and involving multiple systems: extremities, abdomen, chest and often face and neck. He sees and learns to evaluate wounds caused by high velocity missiles and those caused by shrapnel. He automatically learns to treat the constant problem of heat exhaustion, salt depletion, malaria, dysentery, amebiasis, etc., and to con-

General medical officers treat "multiple dings" (multiple small shrapnel wounds) of the lower extremities under local anesthesia at Phu Bai.



sider them in his therapy in addition to the traumatic wound. He knows the value of adequate debridement, as well as the problems of inadequate debridement; of delayed primary closure, and the necessity for adequate blood and fluid replacement. He has seen and treated a greater number of young men who need immediate expert care if they are to survive than he will ever experience again in a lifetime of civilian practice. While on his tour with the "grunts" he establishes and uses his aid station as home base to provide preventive and actual needed care

of the minor wounds and illnesses of the 1000-plus men in his battalion.

For his second four month block, the GMO will be the medical officer in a support outfit such as the tanks, engineers, shore party or other separate battalion. Basically, the job is the same; however, the tent, the fighting hole, the C-rations, and the bunkers are less a part of his daily routine. Living is more comfortable, medals are fewer, but life is softer.

The general medical officer then spends four months in the Medical Battalion. Here he holds sick call,

initially examines, evaluates, and treats the casualties as they arrive from the field. He initiates life-saving procedures, such as tracheostomies, insertion of chest tubes, pericardial taps, venous cutdowns, etc., while at the same time ordering the appropriate blood and radiologic studies required prior to sending the casualty to surgery. This is all done under the direction of the Triage Officer, a trained general surgeon. The GMO then assists and at times performs the necessary surgical procedures with the orthopedist or general surgeon. The



Commander Robert A. Brown (Medical Corps) U. S. Navy, our "Dateline: Vietnam" author, administers an anesthetic to a patient at Phu Bai.

GMO does all of the minor debridements under local anesthesia, is responsible for a ward, and does delayed primary closures on the less severely wounded prior to their return to duty.

The general duty physician has the opportunity to work with the internist, the psychiatrist, and the anesthesiologist, if these specialties are in his area of primary interest. The specialist and partially trained specialist normally will serve the entire tour in the Medical Battalion practicing their specialties.

Khe Sanh Combat Base was a relatively quiet Marine base in the Northwest Sector of I Corps for the latter half of 1967. Gradually, then suddenly, a massive infiltration from the north necessitated the movement of approximately 5,000 troops, mostly Marines along with Sea Bees and Navy Medical Support groups, to the base. The story of the siege of Khe Sanh is well known by its national and international coverage by the press.

The medical support of this base is a story in itself. It is one of frustration, of apparent apathy, of hard work, of heartache, of pride, of a real sense of accomplishment, of dedication to duty: a true story of the combat physician, his paramedical team, and the fighting Marines they support.

Medical Company C ("Charlie Med") consisted of Dr. James Finnegan as the senior medical officer, and three non-Pennsylvanians, Drs. Feldman, Wolfe, and Magilligan, as the other physicians. Twenty corpsmen and two Marine ambulance drivers made up the remainder of the personnel. As the Battalion Commanding Officer, the author spent approximately three to four weeks at the base in the early phases of the siege in order to get the necessary bunkers constructed and equipment necessary to do the job.

From January 21, 1968, when the siege began, through April 23, 1968 when "Charlie Med" moved out, we watched a medical unit in tents above ground be wiped out by enemy artillery, mortar and rocket fire. We, the medical personnel, by pleas, threats, and hard work over the twelve to fourteen week period were able to have constructed sufficient underground bunker space to care for casualties and to protect the medical and paramedical personnel. The Medical Battalion, through its Commanding Officer, had the responsibility to provide not only medical care for all casualties, but in addition to protect its personnel. From January 14, 1968 through April 22, 1968, 2,541 patients were seen and



Lieutenant Joseph G. Cesare (Medical Corps) U. S. Naval Reserve, of Old Forge, Pa., (top center) preparing for debridement of a small shrapnel wound under local anesthesia. . . Patients awaiting X-ray (left) prior to admittance to the operating room. . . General medical officers (below) evaluate newly arrived casualties at Phu Bai. The Triage Officer in the center of the photo directs and controls the priority treatment of each casualty based on the GMO's examination and evaluation.





A typical Battalion Aid Station in the field, in support of the 2nd Battalion, 4th Marines, north of Dong Ha, south of the DMZ.



The doctors' "hootch" (quarters) at Khe Sanh, built before the siege. This building was destroyed by a direct artillery round hit. At this time, the doctors were living underground.

treated. Of these, 2,031 were wounded in action and 490 were non-battle casualties. We evacuated 2,249 patients, by fixed wing aircraft very early in the siege, but later entirely by helicopter. Of these, 292 were returned to duty. These patients demonstrated every conceivable type of wound one could receive from enemy sniper fire and shrapnel from enemy artillery, rocket and mortar fire.

The medics at Khe Sanh enjoy a close association with the chaplains, who also support the Marine unit and who have paid a toll in lives and wounds among their corps. Father Kelly, a young priest from Philadelphia, was responsible on St. Patrick's

Day for one of the more memorable and meaningful experiences for all of us at Khe Sanh. He celebrated a mass and then held a Protestant service in a bunker, during a heavy artillery attack. He managed to serve the troops green apple juice, green cake, and ice cream—a real feat at that time in Khe Sanh, when the bill of fare consisted of C-rations and rationed water. He appointed Dr. Feldman the Grand Marshall of the St. Patrick's Day parade, since he was the only Jewish male present. Dr. Feldman then paraded with green pennant and top hat to the underground bunker used as living quarters for the physicians. There, to the tune of old Irish songs by a young

Marine lieutenant, the company celebrated the day with a toast from a bottle of Scotch, which somehow mysteriously appeared.

In keeping with the St. Patrick's Day spirit, a young corpsman who had to go out to the strip to wave a flag to guide the helicopter pilots to the Medical Evacuation site, decided he no longer wanted to be a target for incoming mortar fire. He therefore sandbagged a parachute and pinned a large shamrock cut out of a government blanket to the parachute and by radio informed the pilots to use it as a guide. It did just that until just before "Charlie Med" was evacuated from Khe Sanh.

Doctor Brown and Corporal Sullivan on the airstrip at Khe Sanh, St. Patrick's Day. A young corpsman who had to go out to the strip to wave a flag to guide helicopter pilots to the Med Evac site decided he no longer wanted to be a target for mortar fire. He sandbagged a parachute and pinned a large shamrock (cut from a government blanket) to it and radioed pilots to use this for their guide.





Charlie Med in tents above ground prior to the siege of Khe Sanh.



A CH-46 helicopter off-loads patients at Delta Med in Dong Ha where definitive care can be given to troops who arrive from Khe Sanh.

Third Medical Battalion personnel, in times of decreased enemy activity, maintain a very active people-to-people program, medically speaking. A volunteer pediatrician, on duty with the Third Division, has been instrumental in setting up an active immunization, maternal welfare and pediatric clinic in Phu Bai. A clinic building has been constructed and is operated by the local Vietnamese health officials, with the help of the Battalion.

Our general surgeons, orthopedists, and anesthesiologists and their Vietnamese counterparts alternated one day a week at the Army of the Republic of Vietnam (ARVN) Hospital and one day a week at the Medical Battalion, to teach some of our newer techniques

to the Vietnamese physicians. The Battalion also provided the equipment and nursing care which was not available at the ARVN Hospital. This particular program has been extremely well received by the Vietnamese Army Medical Service and by our staff here.

The ARVN 1st Division Hospital in Hué had a very heavy casualty load prior to the Tet Offensive, with less than adequate facilities and an overworked physician staff. Usually twelve to fifteen doctors represented the total staff for the care of 700 to 900 patients. Most of the time the less seriously wounded shared beds, since the bed capacity does not exceed 600.

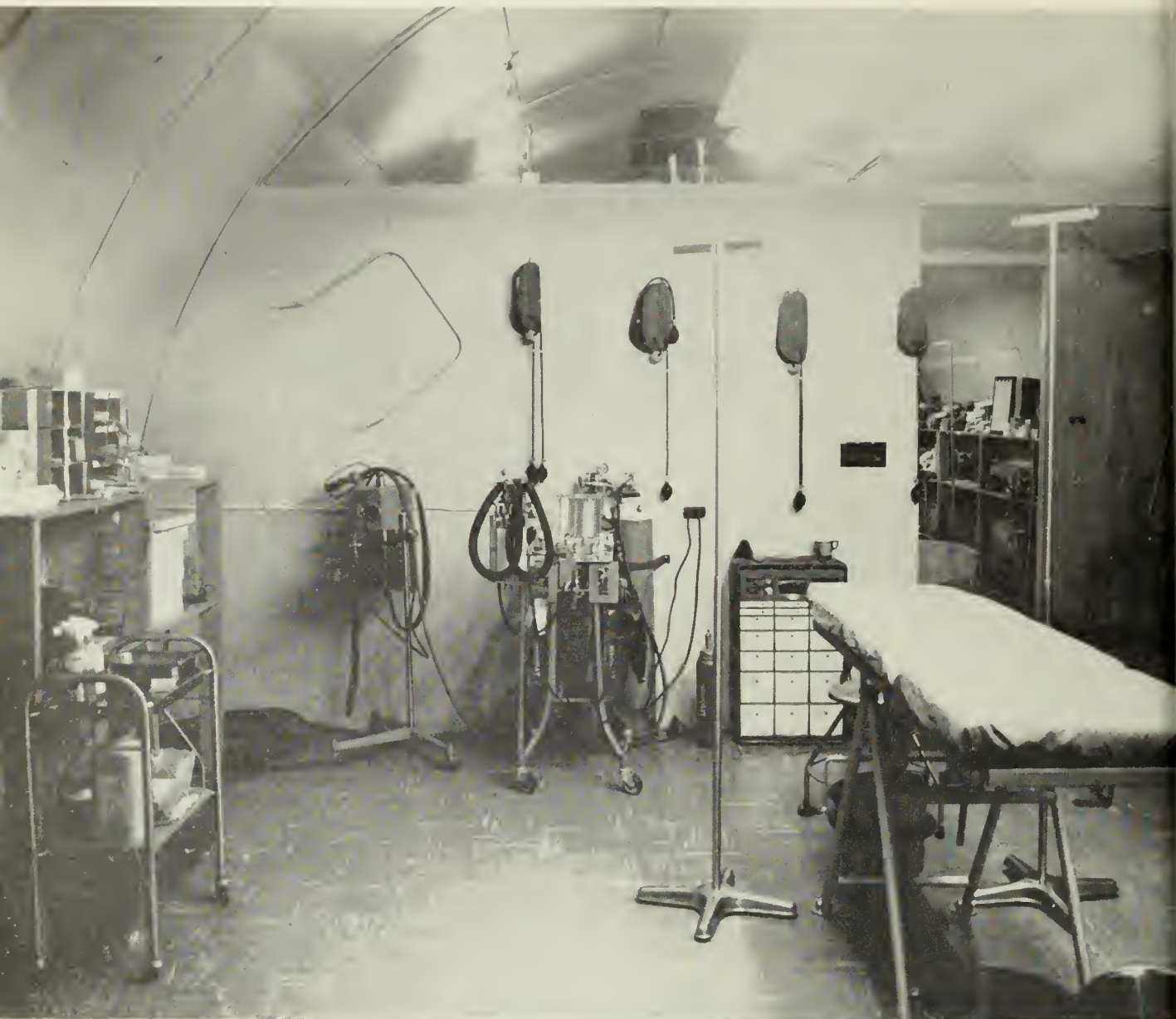
One general medical officer with a year of training in internal medicine

was the only doctor available to take care of approximately 250 active tuberculosis patients in a hospital in Hué, in addition to his primary duties within the Battalion. The orthopedic surgeons have a very active Vietnamese clinic, treating club feet, residual polio cases, and other congenital as well as acquired traumatic defects of the extremities. Before the Tet Offensive, our oral surgeon was repairing approximately two cleft palates a week. This is a very common congenital defect in the surrounding villages. Many families will bring in two or three siblings, all with the same defect.

At Phu Bai, the Third Medical Battalion at present has approximately 180 beds and six operating rooms with



Doctors Finnegan and Brown in a typical uniform-of-the-day at Charlie Med, Khe Sanh, February 1968.



The operating room (above) of Delta Med, 3rd Medical Battalion, Dong Ha. . . . The Alpha Med unit of the 3rd Medical Battalion (right) as seen from the Phu Bai civilian airport tower. The building with the Red cross is the triage area. Casualties arrive at this point by planes and 'copters. The hospital complex is hidden behind the tree cover.



sufficient personnel to maintain around-the-clock operations in all operating rooms when the casualty load requires. Neurosurgical, ophthalmologic, and urologic emergencies as well as routine consultations in these specialties are usually referred to the hospital ships off shore or to the Naval Support Activity Hospital in Danang where these specialties are represented.

The Medical Battalion maintains a clearing platoon at Khe Sanh and a 30-bed, three operating room, fixed facility at Dong Ha, with sufficient specialists, general medical officers, and paramedical personnel to provide definitive care to any casualty it may receive.

During the Tet Offensive, when the casualty load was extremely heavy, the Third Medical Battalion performed 1630 major surgical procedures on 917 patients. In addition, 1943 casualties had major wounds which were debrided under local anesthesia. The Battalion treated 10,146 outpatients and transfused 3850 units of whole blood. Admittedly, this was a peak load, but the above figures do indicate the capabilities of the medical support of a Marine division.

The role of the Medical Battalion in support of the Third Marine Division is quite different from the classic concept of support as is the role of the Marine Corps in the Republic of Vietnam. The usual Fleet Marine Force amphibious assault across a beach requires mobility and displacement capability of all its support elements including the Medical Service. As the assault moves inland, the classic concept of a Collecting and Clearing Company, capable of providing life-saving surgery in tents, with subsequent evacuation seaward, does not apply in the present deployment.

After treatment by a corpsman in the field, most of the casualties are taken directly from the field to the Medical Battalion for definitive care. This rapid evacuation by helicopter is the one single factor which has altered some of the classic concepts of medical support and casualty evacuation. The helicopter alone has accounted for the survival of many seriously wounded men, who otherwise would not have survived were it not for the proximity to the combat area of controlled environmental facilities and trained specialists.

The Medical Battalion Commander has the overall responsibility of providing facilities and specialty care for the acute surgical, orthopedic, medical

and psychiatric casualties generated within the Division. In addition to actual combat casualties, the Medical Battalion provides specialty care and hospitalization for all of the routine surgical and medical patients encountered in caring for any large population of healthy young men.

In summary, during my tour in Vietnam with the Third Marine Division I can honestly say the wounded were always treated promptly and adequately; they were evacuated and handled expeditiously. This does not mean that the physical plant could not have been better. Comfort to the troops when they arrived in need of medical care could and should have



Father Kelly, a young priest from Philadelphia, celebrated Mass and held a Protestant service in a bunker during heavy artillery attack on St. Patrick's Day.

been better. Khe Sanh presented to Dr. Finnegan and myself an unprecedented opportunity to serve as combat physicians. Ingenuity, patience, physical endurance and emotions were tested. Duty with the Marine Corps as a physician is neither all good nor all bad. Frustration, aggravation, boredom and fear are always present in varying degrees. The dedication, the faith and spirit of the fighting Marines and the corpsmen who walk the same trail, face the same danger, and respond to the call of "Corpsman up" without concern for personal safety, makes the role of the combat physician a privileged one.

Curricula Vitae

PENNSYLVANIA M.D.'s OF "DATELINE: VIETNAM"

Commander Robert A. Brown (Medical Corps) U. S. Navy, was born in Frackville, Pa. He attended medical school at Jefferson Medical College where he received his M.D. in 1955. He served his internship at the U. S. Naval Hospital, Newport, R. I. and residency at the University of Pennsylvania Hospital (anesthesia) 1956-58. He was Commanding Officer of the 3rd Medical Battalion in Vietnam from August 1967 until this month when he is scheduled for reassignment.

Lieutenant James Finnegan (Medical Corps) U. S. Naval Reserve, was born in Pittsburgh, Pa. He attended medical school at Hahnemann Medical College where he received his M.D. in 1964. He served his internship at Hahnemann from 1964 to 1965 and his residency at the University of Pennsylvania Hospital (general surgery) from 1965-1967. At the writing of this article, he is Medical Officer of the 3rd Medical Battalion.

Lieutenant Joseph G. Cesare (Medical Corps) U. S. Naval Reserve, was born in Old Forge, Pa. He attended medical school at Creighton University, receiving his M.D. in 1965. Doctor Cesare served his internship at Lankenau Hospital, Philadelphia, from 1965 to 1966.

(Editor's Note: There are other Pennsylvania physicians on duty with the Marines in Vietnam performing as valiantly as those we have read about here. To have found them all by printing deadline time would have been an impossibility. The editors of Pennsylvania Medicine wish to express their gratitude to the U. S. Navy, and especially to Vice Admiral R. B. Brown, Medical Corps, USN, Surgeon General, his staff, our author and his shipmates on the battlefield, without whose cooperation this story would have been impossible. All photographs Official U. S. Navy or Marine Corps.)



Adrenergic Blocking Agents in Cardiovascular Disease

Part I

What are adrenergic blocking agents?

These are chemical agents which antagonize the cardiac and peripheral vascular effects of the catecholamines (isoproterenol, norepinephrine and epinephrine), by blocking the response of alpha and beta adrenergic receptors. Adrenergic receptors are classified as alpha and beta based on their response to isoproterenol. Those which are most sensitive to isoproterenol are termed beta receptors and those least sensitive are alpha receptors. The heart and bronchioles contain chiefly beta receptors; arteries and veins have both alpha and beta receptors and the metabolic pathway for glycogenolysis is controlled by the beta group.

What is the action of the catecholamines on the beta receptors?

The catecholamines increase the rate of onset and strength of myocardial contractility, normal and abnormal pacemaker activity and the velocity of A-V nodal conduction. The bronchioles are dilated by the catecholamines. The stimulation of the beta receptors in the peripheral circulation dilates the arterioles and produces mild constriction of the venules. Glycogenolysis can also occur, producing a secondary hyperglycemia.

What is the action of the catecholamines on the alpha receptors?

Stimulation of alpha receptor sites produces constriction of peripheral arterioles, peripheral venules and vasoconstriction of the renal and splanchnic beds.

What are the clinical value and pharmacologic action of the major beta blocking agent?

Propranolol hydrochloride is the most potent beta adrenergic blocking agent in clinical use today. It is effective in the treatment of cardiac arrhythmias since it slows both normal and abnormal pacemaker activity and decreases the velocity of conduction through the A-V node. Some physicians find it effective in the treatment of angina pectoris since it decreases the strength of myocardial contractility and heart rate which, therefore, decreases the oxygen requirements of the heart. With the use of propranolol, the bronchioles lose their ability to dilate, making this drug contraindicated in asthma.

What are the important alpha adrenergic blocking agents and what are their pharmacologic actions?

The most important alpha adrenergic blocking agents are phenoxybenzamine and phentolamine. These drugs block the vasoconstrictor and vasopressor actions of norepinephrine and epinephrine. They are useful in the treatment of hypertension secondary to pheochromocytoma or in hypertension secondary to the hypersympathetic state.

Does propranolol block the effect of digitalis glycosides on the contractile force of the heart?

The action of digitalis glycosides, calcium chloride or theophylline, on the contractile force of the heart is not blocked by the use of propranolol.

Can propranolol be used to control heart rate?

This drug rapidly and consistently decreases the ventricular rate in atrial fibrillation, atrial tachycardia and atrial flutter. It is also excellent in the con-

trol of sinus tachycardia in children and in hyperthyroid disease.

What blocking agents can be used in the treatment of pheochromocytoma?

Propranolol, through its beta blocking activity, decreases the rapid heart rate in pheochromocytoma. However, the alpha adrenergic blocking drugs, such as phentolamine and phenoxybenzamine, reduce the hypertension. Therefore, a combination of alpha adrenergic blockade and beta adrenergic blockade is useful prior to, during and after surgery for pheochromocytoma.

In what other cardiac condition is propranolol of clinical value?

In hypertrophic subaortic stenosis, it relieves the outflow tract obstruction. It also controls the angina, syncope and palpitation which complicate these cases. The usual dosage is 20 to 40 mg. orally three to four times daily. It is of use in the control of hypercyanotic spells and episodes of dyspnea in children with Fallot's tetralogy. The oral dose is useful in the prevention of the hypercyanotic spells and intravenous dosage is effective in the treatment of spells of dyspnea.

William G. Leaman, Jr., M.D. questions **M. Price Margolies, M.D.**, Chief of the Department of Medicine and Director of the Heart Station, Coatesville Hospital, Coatesville, Pennsylvania.

William G. Leaman, Jr., M.D., Fellow, Council on Clinical Cardiology of the American Heart Association, edited this Brief for the Council on Scientific Advancement, in cooperation with the Pennsylvania Heart Association.



Let's be specific about Campbell's Soups... and reducing diets

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101



SUNDAY



MONDAY



TUESDAY



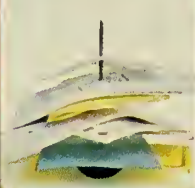
WEDNESDAY



THURSDAY



FRIDAY



SATURDAY



Ovulen-21[®]

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

works the way a woman thinks

by weekdays...not "cycle days"

Whether it be "shopping day," "bridge day" or "housecleaning day," a woman is accustomed to thinking in terms of days of the week rather than in "cycle days." Ovulen-21 lets her remember her natural way. Once established, her starting day is always the same day of the week...because it is fixed at three weeks on — one week off and is independent of withdrawal flow.

The same Ovulen in the same low dosage... with the same low incidence of side effects and the same high degree of protection against pregnancy.

Note: Ovulen remains available in the familiar round Compac for those women who may wish to continue to use the traditional 20-day schedule. Be sure to specify Ovulen-21 to assure each new patient of the advantages of the new *Three Weeks On—One Week Off* schedule. She might appreciate your budget-minded authorization for a six-month supply (five Refills).

Indication — For oral contraception.

Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young

patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein[®] and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T³ values; metyrapone test and pregnandiol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of a menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

Postpartum administration — Non-nursing mothers may begin Ovulen immediately after delivery and nursing mothers after lactation is well established.

Before prescribing see Detailed Product Information.

SEARLE

G.D. Searle & Co., P.O. Box 5110, Chicago, Illinois 60680

Ovulen-21[®]

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

three weeks on...one week off

In the complex picture
of moderate to severe anxiety...



there is a **new** reason
for prescribing **Mellaril**
(Thioridazine HCl)

**effectiveness in
mixed anxiety-depression**

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril[®]
(Thioridazine HCl)
25 mg. t.i.d.

**for moderate to severe anxiety
and mixed anxiety-depression**



CAN CANCER BE PREVENTED?

For years, the American Cancer Society has placed before the public seven constant reminders aimed at helping individuals detect early signs of cancer—signs that when studied by you, doctor, might reveal an early, highly curable malignancy.

The Society's SEVEN WARNING SIGNALS have appeared in films, brochures, books, magazines, and over the broadcasting airwaves. Public awareness of these signals has undoubtedly been responsible for many of the 1,500,000 Americans alive today, cured of cancer.

But lives are still being needlessly lost to cancer. Despite the constant exposure of the SEVEN WARNING SIGNALS, many patients are coming to you too late for proper and effective treatment.

Something new was needed—something that could pay even bigger dividends in lives saved. The new concept now adopted by the Society is called the SEVEN SAFEGUARDS, and features seven steps that can prevent or detect cancer long before the appearance of a warning signal. There's a safeguard for each of the major sites of cancer plus another for the whole body; seven sites counterbalanced by seven safeguards this way:

SEVEN SAFEGUARDS



SITE

Breast
Colon-Rectum
Lung
Mouth
Skin
Uterus
Whole Body

SAFEGUARD

Self-Examination, Monthly
Proctoscopy, annually after 40
Don't Smoke
Dental Exams Regularly
Avoid Excessive Sun
Pap Test Regularly
Complete Check-up Annually

During the next several months you will be hearing much about this new public education concept. The SEVEN SAFEGUARDS will be communicated in the same ways the public heard about the warning signals.

Our monthly page in PENNSYLVANIA MEDICINE will be written by prominent physicians around Pennsylvania and will be aimed at reminding all physicians of the techniques and procedures employed routinely in the physical examination. We'll also have special pages devoted to help you

teach the techniques your patients must know such as breast self-examination.

Our aim is to save lives. And we think the best way to save lives from cancer is to prevent it. Combining our talents and urging the public to practice cancer's SEVEN SAFEGUARDS, seems to us an effective and profitable path to follow.

If you would like lists of cancer's SEVEN SAFEGUARDS to give your patients, call, write or visit your local American Cancer Society Unit.

AMERICAN CANCER SOCIETY

PENNSYLVANIA DIVISION

PHILADELPHIA DIVISION

PENNSYLVANIA CANCER FORUM PAGE—presented cooperatively by the Council on Scientific Advancement of the Pennsylvania Medical Society, the Pennsylvania and Philadelphia Division of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health.



Cockroaches and Cherry Stones

by

Dwight L. Wilbur, M.D., President
American Medical Association

(Editor's Note: The following article is an abstract prepared by George E. Farrar, Jr., M.D., President-Elect, Pennsylvania Medical Society, for the members of the Society in the hope that every member will read Doctor Wilbur's implementation of the phrase used by his father: ". . . emphasize steering instead of the brake. . ." The unabridged speech, delivered in San Francisco, Calif., June 20, 1968, appears in the *Journal of the American Medical Association* 205: 92-96, July 8, 1968.)

The most important function of local and state medical associations and the AMA is to plan—plan thoroughly and wisely toward the goal of medical care of high quality for everyone in America.

Doctor William Osler, the greatest figure in clinical medicine in this or any country in the past 100 years came from Montreal to the University of Pennsylvania in 1884 because he passed the "cherry stone" test. Osler wrote as follows:

"Doctor Mitchell (S. Weir Mitchell, the great neurologist and novelist) cabled me to meet him in London as he and his good wife were commissioned to 'look me over' particularly with reference to personal habits. Doctor Mitchell said there was only one way in which the breeding of a man suitable for such a position, in such a city as Philadelphia, could be tested. Give him cherry pie and see how he disposes of the stones. I had read of the trick before and disposed of them genteelly in my spoon and got the chair."

Were the cherry stones important? Of course they were—they were the crucial test by the standards of those days. By being prepared, by planning and, if you will, in part by accident, Osler's selection was accomplished—an incident that almost completely changed medicine in this country.

What about cockroaches? They were responsible for the establishment of the first university hospital in this country—again, at the University of Pennsylvania. In the 1830's and '40's, the University had reached the high point of clinical education through its affiliation with the Philadelphia Hospital (subsequently the Philadelphia General Hospital). There were rumblings of political difficulties but it was an absurdly trivial cause that, for nine years, closed the wards to students.

The trouble-making specimens of *blatta orientalis* made their appearance one day in June on the dining room table of the stewards' mess, at which the resident physicians took their meals. As the story goes: "The disgusted interns demanded they be transferred to the matron's table where (they hoped) better housekeeping prevailed. Their request was refused and they at once resigned their posts."

Further political difficulties for years with Philadelphia's Board of Guardians of the Poor finally led the great Doctor William Pepper, Professor of Medicine and Provost of the University, to establish the Hospital of the University of Pennsylvania.

Here, then, by accident, induced by reaction to a few innocent cockroaches, was established the need for complete control by the University of its own hospital, free of city politics.

Problems of Today

The goal we seek is a high quality of medical care for every American. Having gained the leadership in scientific achievement in medicine, we must now act to assure leadership in the larger area of social and economic changes.

As a profession and as members of society, our greatest problem is that many people are not receiving the benefits of physicians' services and what modern medicine can offer.

For many people, the barriers are ignorance or financial, social and geographic factors. The ignorance is of what medicine has to offer and how to get into the system—how to find the right physician at the right time and the right place. Financial barriers still exist for many people despite the wide and extensive use of voluntary health insurance and government programs of financing medical and health care. Problems of status and other psychological blocks still harass many who fear or lack understanding. Finally, geographic barriers in the urban areas, and even more in the rural areas, often make access to medical care difficult.

Does the following sound familiar? "I believe the time has come when we must place ourselves in a more intimate relationship with the people than has heretofore ruled; in other words, the people are looking to us to utilize the capacity which this Association actually possesses, for the general welfare."

This was part of the inaugural address 95 years ago of one of my predecessors, Doctor Thomas M. Logan of Sacramento, Calif.—the first AMA president from the West. And 45 years ago, in his inaugural address, my father, Doctor Ray Lyman Wilbur, clearly and prophetically described our present situation as follows:

"The social relationships of medicine are so intimate and imperative that they are bound to multiply and continue. We cannot stop them by calling them Bolshevik or socialistic or pro-German (today we would say communistic) but we can guide them if we get away from the brake and begin to steer. We can, too, if we do not think, put on the blinders of prejudice and fail to make a diagnosis and prognosis of society, its sweeping activities and its needs.

"As a profession, we are now deeply entwined in the meshes of legislation and in the services of government. In many instances those outside the profession have, without our aid, made the rules that govern medicine."

What can we as individual physicians and as a profession and association do?

1. We must remain *free . . . unshackled . . .* a profession and not a group of technologists. Some physicians whose activities are highly technical will, by limitation of interest, become increasingly detached from the patient except in performing technical procedures. They, thus, will become physician technologists. But most of us, whether in family practice or in a special field, must obtain a broad physician-patient relationship and understanding so well expressed in these words: "The voluntary association of two men, one giving and one seeking relief—this is the heart of the art of medicine." Clearly, the physician must consider and treat not just the disease but the whole patient. Further, the modern physician, in viewing man as a social animal, must see the great living group of which the patient is but a unit. For him, service to humanity has greater appeal than dedication to science. Through all this, we must keep free the individuality of the patient and of the physician.

2. We must exercise cooperative leadership of all those in the health care field—government, industry, labor and all segments of the public. Our knowledge of health is unique and indispensable, but it is not our peculiar possession and it cannot remain in a vacuum.

3. Doctor Malcolm Todd, President of the California Medical Association, expressed it well when he said: "By involving ourselves in the local implementation of this program (P. L. 89-749 and 90-179) we can lead rather than be led, we can guide rather than be directed, and we can improve our health care system according to values we know to be paramount, rather than having bureaucratic programs developed for us."

4. In the field of health we must lead everyone to understand the difference between needs and demands or face highly emotional situations that bring on political efforts at solution.

5. So little is known now of the economies of health care as rendered by the solo practitioner; by the group, be it on a fee-for-service basis or otherwise; by the specialist or the generalist; by the hospital-based physician, and by the physician in rural and urban centers. What are the differences? Let neither physicians nor the public be led by the siren song of those who, in the awesome self-assurance of the ill-informed, could in their blundering destroy the health care available to the American people. Whatever is needed, we must become the experts.

6. We must demonstrate the effectiveness of the private system of medical care and of the voluntary health insurance mechanism. As Russell Roth has so clearly expressed it: "government has not pioneered in economy in medical care." We must now, by effective leadership, make the voluntary system of health insurance increasingly effective, efficient and comprehensive.

7. Inflation, increased population, greater demands and utilization by consumers, more accessible and expensive facilities, rising costs of personnel and highly technical services, and payment for services by third parties, private and government, will inevitably raise costs of and expenditures for health care.

We must make every reasonable effort to hold down health care costs by making use of hospital beds only when clearly necessary; by encouraging the development of more extended care facilities and nursing homes; by making every effort to encourage carriers to increasingly cover the costs of care outside the hospital, in the home and office, for prescription drugs, private duty nursing and the services of others in allied health services. This should be done without losing sight of the major end in health care—quality of care, rather than low cost. We must encourage physicians to follow the principles of the usual, customary and reasonable fees, of peer review and self-discipline, because they are responsible members of the profession and not because of fear of government reprisal.

8. We must expand medical school facilities, encourage education of more nurses in hospitals and in community and other colleges and increase the number of persons in the allied health professions. As a profession, we should actively participate in the education of all of them.

9. We must continue supporting research in the prevention of disease through established programs.

10. Doctor Charles L. Hudson expressed it well in November, 1966, in his address to this House: "I propose that the AMA and state and county medical societies launch a continuing program, under predominantly private auspices, to improve existing health care services and establish new services where they do not exist, for all

persons of whatever age, race, creed or color. This program will vary from one community to another and will require substantial support and cooperation from non-medical, civic-minded groups. I consider this kind of program a top-priority AMA obligation."

11. As physicians and citizens, we should effectively, enthusiastically and widely support AMPAC and the state PACs. In its financing of health care, the government is our largest single customer.

To broaden and increase the usefulness of our association, we need particularly close liaison with the public, with many associations of lay groups that have active or potential interest in health and medical affairs. And, within the profession, we have great need for closer association with young physicians in internships and residencies, with medical students, with medical specialty societies and with other professional groups.

The AMA has selected a group of distinguished citizens from important spheres to serve at the national level as its Advisory Committee on Health Care of the American People. This committee will advise the Board and the Association concerning public attitudes in medical and health affairs.

This association was formed before there were interns and residents. Now there are approximately 45,000 of them in our hospitals—all M.D.s, the majority with licenses and actively participating in the practice of medicine. Why do we not accept them into membership of our county, state and national associations after they receive the M.D. degree, and certainly when they become residents? Such a move would greatly strengthen our profession and our association, bringing to it the idealism, stimulation and exuberance of youth, and at the same time bring to the interns and residents a feeling of participation and a view of the judgment, mature and experienced, of those of us who for some time have actively practiced the profession.

We would be wise, too, if, through student membership, we could similarly relate to all medical students. Their interests in people, their desire to participate in health problems of people and communities, are among the principal reasons for their entry into medical school. We and they would benefit by mutual involvement and support.

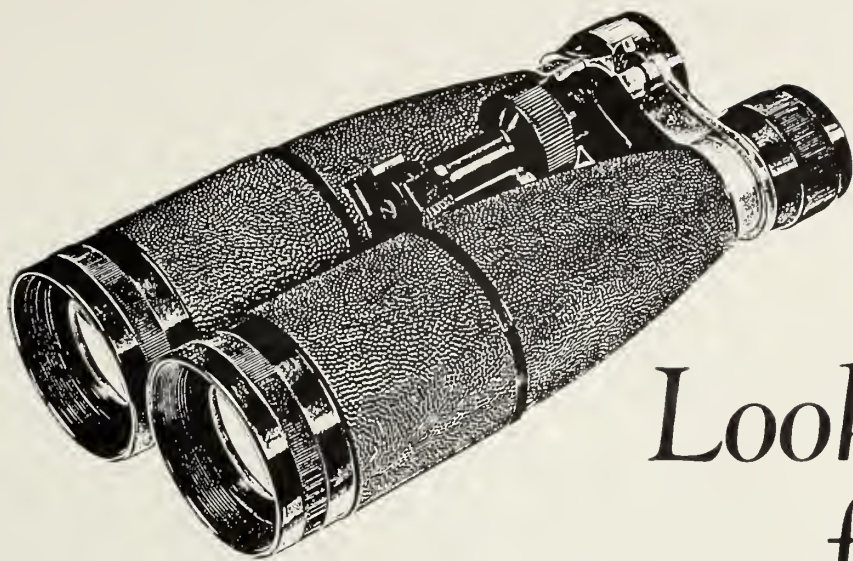
Within the profession, we recognize the centrifugal forces of fragmentation. The AMA has already instituted efforts through the Interspecialty Committee of the Board.

Similarly we need increasing relationships with those whose primary interest is in health facilities, such as hospitals, extended care facilities, nursing homes, home care and related services.

Notes for the Future

Our profession has met and surmounted many crises in the last 60 years. With all our knowledge, skill and ability we can tip the scales, if we will, in behalf of the private system of medical care. We can do so by exerting the leadership that it is our responsibility to give. The best medical care can be rendered by the physician who is free to make his own decisions and is not hopelessly encumbered by all those forces that by their very presence interfere with the splendid voluntary association of patient and physician—the one seeking, the other giving, both gaining.

We are among the most privileged of men to have this challenge.



Looking for Something?

Try PENNSYLVANIA MEDICAL SOCIETY PHYSICIAN PLACEMENT SERVICE

Pennsylvania Medical Society offers assistance through its Placement Service for physicians seeking locations as well as communities seeking additional medical coverage. There are registrations in most specialties and general practice. List of physicians in various specialties available on request. Communities seeking general practitioners are requested to list with the Service.

For further information, contact:

PHYSICIAN PLACEMENT SERVICE

PENNSYLVANIA MEDICAL SOCIETY
TAYLOR BYPASS AND ERFORD RD.
LEMOYNE, PENNSYLVANIA 17043





⊙ Indicates courses being conducted in Pennsylvania.

ARTHRITIS & RHEUMATISM

⊙ **Newly Recognized Aspects of Rheumatoid Arthritis;** by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, October 10, 1968; 11:30 a.m. to 2 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

CARDIOVASCULAR

⊙ **Short Course on Cardiac Arrhythmias;** by Jefferson Medical College and Penn State University; at *St. Luke's Hospital, Bethlehem, Thursdays, September 19, October 17, November 21 and December 19, 1968; 9:30 a.m. to 12 noon*; fees: \$16 for four sessions; \$7 per single seminar; AAGP 3 hours per session. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

CARDIOVASCULAR DISEASE

The Metabolic Basis of Heart Disease; by the American College of Physicians; at Wayne State University School of Medicine, *Detroit, Michigan, Thursday, September 26-29, 1968*; fees: members \$60, non-members \$100. Contact Edward C. Rosenow, Jr., M.D., American College of Physicians, 4200 Pine St., Philadelphia 19104.

GENERAL MEDICINE

⊙ **Current Concepts of Thyroid Disease;** by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, September 12, 1968; 11:30 a.m. to 2 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

⊙ **Practical Application and Treatment of Diabetes, Heart Disease, Ulcerative Colitis;** Annual Meeting of Blair County Chapter of AAGP; at Penn Alto Motor Hotel, *Altoona; Saturday, September 7, 1968*; AAGP credit applied for—4 hours; fee \$50.00; minimum number required 50; maximum number permitted—un-

limited. For further information contact Philip W. Hoovler, M.D., The Altoona Hospital, Altoona 16603.

⊙ **Continuing Education;** at *Pottsville Hospital; Thursday, September 12, 1968 to June 1969*; one day per month, 10 months; no fee; AAGP credit 20 hours. Contact E. W. Cubler, M.D., Pottsville Hospital, Pottsville 17901.

⊙ **Retraining Program for Women Physicians;** by Women's Medical College of Pennsylvania, at *Philadelphia, Monday, September 23, 1968-May 28, 1969*; 672 course hours; no fee (stipend offered); minimum required 5, maximum 10. Contact Ethel Weinberg, M.D., Assistant to the Dean, Woman's Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia 19129.

⊙ **Recent Advances in Medicine;** at Temple University Health Sciences Center, *Philadelphia, Wednesday, October 16, 1968, 8 days, 32 hours*; fee \$50. AAGP credit applied for. Contact Albert J. Finestone, M.D., Temple University Health Sciences Center, Broad & Ontario Sts., Philadelphia 19140.

GERIATRICS

⊙ **Training in Geriatric Psychiatry;** by Coatesville Veterans Administration Hospital. Four months to one year training program for physicians. Program involves group and individual psychotherapy with geriatric patients, milieu therapy, physical rehabilitation, drug therapy, family therapy, and post-hospitalization care. Contact Kurt Wolff, M.D., Veterans Administration Hospital, Coatesville, Pa. 19320.

IMMUNOLOGY

⊙ **Immunity—How Much and to What?** A review of the modern concepts of the measurement and identification of immunity and the use of immunoproteins in diagnosis; by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, September 19, 1968*; fee: \$50 for 112 hour, 28 day Continuing Seminars in

Medical Education; AAGP credit 100 hours. Full day visit with afternoon rounds. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

INTERNAL MEDICINE

⊙ **Electrolyte Metabolism and Renal Disease;** by Pennsylvania Medical Society; at *Chatham Center, Pittsburgh; Sunday and Monday, October 27 and 28, 1968*; fee for course \$25, non-members \$35. Nurses and Paramedical Seminar on Renal Diseases, *Monday, October 28*; Specialty Society Meetings, *Tuesday, October 29*. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

⊙ **Current Concepts of Thyroid Disease;** by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, October 24, 1968*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Two day visit, October 24 and 25. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

⊙ **Renal Disease: Pathologic Physiology;** by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, October 17, 1968; 8:45 a.m. to 12:30 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

METABOLISM

⊙ **Inborn Errors of Metabolism;** by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, October 3, 1968; 8:45 a.m. to 12:30 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

NEUROLOGY

Course in Clinical Electroencephalography; by American EEG Society; in *San Francisco, California; Monday, September 9-11, 1968*. Contact Don-

(Continued on next page)

ald W. Klass, M.D., Mayo Clinic, Rochester, Minnesota 55901.

○ **The Neurologist Looks at Stroke;** (Modern approaches to diagnosis and care); by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, September 26, 1968*; fee: \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **The Neurosurgeon Looks at Stroke;** (The acute approach to repair and prevention of spread); by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, October 3, 1968*; fee: \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Two day visit, October 3 and 4. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

OTOLARYNGOLOGY

Course in Laryngology and Bronchoesophagology; by the department of otolaryngology, College of Medicine of the University of Illinois; at new Illinois Eye and Ear Infirmary, 1855 West Taylor St., *Chicago, Monday, September 23-October 4, 1968*. Limited to 15 physicians. Contact Albert H. Andrews, Jr., M.D., College of Medicine, University of Illinois, Post Office Box 6998, Chicago, Illinois 60680.

PEDIATRICS

Institutes for Physicians and Nurses in the Care of Premature and Other High-Risk Infants; being continued at the New York Hospital-Cornell Medical Center under the sponsorship of the New York State Department of Health and the U.S. Children's Bureau. Institutes for the 1968-1969 fiscal year have been scheduled as follows: *Physicians* September 16-27, 1968; November 11-22, 1968; January 20-31, 1969; March 17-28, 1969; May 12-23, 1969; *Nurses* September 3-27, 1968; October 28-November 22, 1968; January 6-31, 1969; March 3-28, 1969; April 28-May 23, 1969. Tuition is covered through a special arrangement with the New York Hospital-Cornell Medical Center. A stipend of \$125 is provided to physicians attending the institute to help cover board and lodging for the two weeks. A stipend of \$175 is provided to nurses for four weeks attendance.

Travel expenses must be covered by the participant or by his or her sponsoring agency.

○ **Up to the Minute Pediatrics;** by Woman's Medical College of Pennsylvania at *Philadelphia, September 1968-May 1969*; 4 to 5 hours monthly for seven months; fee: \$5.00 per session (lunch included). Contact Ethel Weinberg, M.D. Assistant to the Dean, Woman's Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129.

○ **Sudden and Unexpected Death in Infancy—A Major Practice Problem;** by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, October 31, 1968*; fee \$50 for 112 hours, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

PHYSICAL MEDICINE

○ **The Physiatrist Looks At Stroke;** by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, October 10, 1968*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

PSYCHIATRY

○ **Family Therapy;** by The Institute of the Pennsylvania Hospital, at *Philadelphia, Wednesday, March 5-May 21, 1969*; fee \$50; minimum number required 10, maximum permitted 15. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

Emotional Aspects of Illness; by The Institute of the Pennsylvania Hospital, at *Morristown Memorial Hospital, Morristown, N.J., Wednesday, September 25-December 18, 1968*. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *Reading Hospital, Wednesday, September 11-December 11, 1968*; fee \$15; minimum number required 15, maximum permitted 25. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Sexual Problems in Medical Practice;** by Hahnemann Medical College and Hospital of *Philadelphia, Wednesday, September 25-November 27, 1968*. Contact Paul J. Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Physician-Community Psychiatrist Seminar;** by Mental Health Guidance Clinic of Butler County, at *Y.W.C.A., 120 West Cunningham St., Butler, 4th Friday of each month, September through June*; AAGP credit, hour for hour; maximum number permitted 20. Contact Robert L. Eisler, M.D., Mental Health Guidance Clinic of Butler County, 128 South Main St., Butler 16001.

○ **Case-oriented Seminars on Psychiatry in Medical Practice;** by Staunton Clinic, at *Pittsburgh, Wednesday, September 18 and 19; Wednesday, December 18 and 19; Thursday, January 2-8, 1969*; fee \$100. Contact Charlotte M. Florine, M.D., Staunton Clinic, 3601 Fifth Ave., Pittsburgh 15213.

○ **Medical Hypnosis;** by University of Pennsylvania Department of Psychiatry, at The Institute of the Pennsylvania Hospital, *Philadelphia, Thursday, September 26-February 20, 1969*; fee \$250; maximum number permitted 45. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *Philadelphia, Thursday, September 26-December 19, 1968*; fee \$50; minimum number required 15, maximum permitted 30. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Graduate Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *Philadelphia, Thursday, September 26-December 19, 1968*; fee \$50; minimum number required 8, maximum permitted 15. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Office Psychiatry & Psychosomatic Medicine—Course #1—Basic;** by Temple University Health Sciences Center, *Philadelphia, Wednesday, October 2, 1968 to February 26, 1969*; AAGP 80 hours; fee \$40; maximum number permitted 24. Contact Barney

(Continued on next page)

M. Dlin, M.D., Temple University Health Sciences Center, Broad & Tioga Streets, Philadelphia 19140.

○ **Office Psychiatry Seminar;** by The Institute of the Pennsylvania Hospital, at Lancaster General Hospital, *Lancaster, Wednesday, October 9-November 27, 1968*; fee \$35; minimum number required 7, maximum permitted 12. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **The Management of Psychiatric Problems by the Non-Psychiatrist;** by Community Mental Health Center, Philadelphia; at Robert Packer Hospital, *Sayre, Wednesday, October 2-November 20, 1968*. Contact Thomas Downey, M.D., Robert Packer Hospital, Guthrie Square, Sayre 18840.

○ **Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at Robert Packer Hospital, *Sayre, Wednesday, October 9, 1968*; eight weeks, 12 noon to 2 p.m. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Psychotherapy for General Practitioners;** by Hahnemann Medical College and Hospital, at *Harrisburg, Tuesday, October 1-December 7, 1968*. Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Psychiatric Problems of Children for Pediatricians and General Practitioners;** by Hahnemann Medical College and Hospital of *Philadelphia, Wednesday, October 9, 1968-February 1969*. Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Sexual and Psychosomatic Problems in Medical Practice;** by The Institute of the Pennsylvania Hospital, at Community Medical Center, East, *Scranton, Wednesday, October 9-December 18, 1968*. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Medicine and the Law;** by The Institute of the Philadelphia Hospital, at *Philadelphia, Wednesday, October 9-December 11, 1968*; fee \$25; minimum number required 15, maximum permitted 25. Contact Sydney E. Pulver, M.D., The Institute of the

Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

SURGERY

○ **Surgical Anatomy and the Techniques of the Temporal Bone;** by University of Pittsburgh School of Medicine and Eye and Ear Hospital; *Pittsburgh, Sunday, September 15-21, 1968, Sunday, November 17-23, 1968*. Attendance limited to 13 physicians; fee \$500/week; contact Ralph J. Caparosa, M.D., 3600 Forbes Avenue, Pittsburgh 15213.

GENERAL

○ **Treatment of Emergencies;** by Episcopal Hospital, at *Philadelphia, Wednesday, October 23-November 13, 1968*; no fee; minimum number required 50, maximum permitted 100. Contact L. H. Stahlgren, M.D., Episcopal Hospital, Front St. & Lehigh Ave., Philadelphia 19125.

○ **Hospital Liability Law;** by The Pittsburgh Institute of Legal Medicine, The Practising Law Institute and the Institute of Forensic Sciences of Duquesne University, at Chatham Center, *Pittsburgh, Friday and Saturday, November 8-9, 1968*. Contact Cyril H. Wecht, M.D., LL.B., Director, The Pittsburgh Institute of Legal Medicine, 1417 Frick Bldg., Pittsburgh 15219.

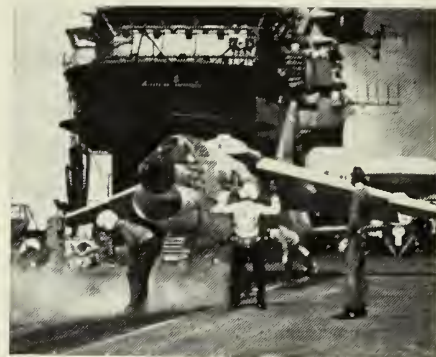
○ **Silicosis and Anthracosilicosis;** by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, March 6, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

○ **Nuclear Medicine Today;** by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, March 20, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

● All organizations presenting continuing education programs for physicians are invited to list details of these programs in PENNSYLVANIA MEDICINE. Programs will be listed up to one year in advance. Information must be submitted three months in advance to assure publication. Please submit a separate request for each program. Continuing Medical Education Publication Request forms are available from the PMS Council on Scientific Advancement, Taylor Bypass and Erford Road, Lemoyne, Pa. 17043.

Buy Bonds

They do.



**U.S. Savings Bonds,
new Freedom Shares**

**WETHERHOLD
AND Famous Shoes
METZGER**

**WE'RE
SPECIALISTS
IN FITTING
"SPECIAL" FEET**



**Orthopedic Fitting and
Orthopedic shoes always in stock**

—ALLENTOWN—

• UP-TOWN STORES
953 Hamilton St.
951 Hamilton St.

• CENTRAL STORE
719 Hamilton St.



○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Harry Fine**, Philadelphia; University of Pennsylvania School of Medicine, 1928; age 64; died April 19, 1968. Dr. Fine was a veteran of World War II. He is survived by two brothers and a sister.

○ **Alfred B. Sigmann**, Conemaugh; University of Buffalo School of Medicine, 1923; age 70; died April 22, 1968. Dr. Sigmann was superintendent at Ebensburg State School from 1960 to 1966. His wife, two sons and a daughter survive.

○ **Kenneth A. Smith**, Wilkes-Barre; Temple University School of Medicine, 1945; age 48; died May 18, 1968. Dr. Smith was a member of the Philadelphia Dermatologic Society. He is survived by his wife and four children.

○ **William Whitaker**, Philadelphia; University of Pennsylvania School of Medicine, 1903; age 88; died April 21, 1968. We have received no information regarding survivors.

Garth W. Boericke, Lansdowne; University of Michigan School of Medicine, 1918; age 75; died January 8, 1968. We have received no information regarding survivors.

Frederick J. Culeman, Malvern; Faculty University of Amsterdam, Netherlands, 1941; age 70; died February 23, 1968. We have received no information regarding survivors.

August C. Valentin, Philadelphia; Jefferson Medical College, 1914; age 79; died May 16, 1968. Dr. Valentin had been plant physician for the H. K. Porter Co. since 1917. Surviving are two sons and a daughter.

○ **Jacques Babbín**, Point Pleasant; New York University College of Medicine, 1919; age 71; died May 18, 1968. Dr. Babbín was deputy coroner for Bucks County and served as editor of the *Bucks County Medical Society Bulletin*. Surviving are his wife and daughter.

○ **Lloyd G. Cole**, Blossburg; University of Michigan School of Medicine, 1911; age 82; died May 22, 1968. Dr. Cole was former surgeon-in-chief at Blossburg State Hospital, a Fellow of the American College of Surgeons and a diplomate of the American Board of Surgery. His wife survives.

○ **Francis C. Eksterowicz**, Philadelphia; Hahnemann Medical College, 1935; age 59; died June 4, 1968. Dr. Eksterowicz served in the Army Medical Corps during World War II and in 1964 was named *Man of the Year* by his local Amvets Post. He is survived by two brothers and a sister.

○ **Herbert J. Frew**, Frackville; Hahnemann Medical College, 1930; age 65; died May 18, 1968. Dr. Frew was a veteran of World War II and served as school physician for the Frackville Public Schools for several years. He was a member of the staff of Locust Mountain State General Hospital. Surviving are his wife, three daughters, two sisters, two brothers and three grandchildren.

○ **Joseph M. Goldberg**, Philadelphia; University of Pennsylvania School of Medicine, 1907; age 83; died June 6, 1968. In 1922 Dr. Goldberg helped found the Northern Liberties Hospital and was medical director and gastroenterologist there from 1926 until the hospital merged with the Einstein Medical Center. Survivors include his wife, two daughters and four grandchildren.

○ **Paul V. Hutchinson**, Pittsburgh; University of Pittsburgh School of Medicine, 1940; age 60; died May 31, 1968. Dr. Hutchinson is survived by his wife, three daughters and a son.

○ **Michael E. McCarthy**, Kane; St. Louis University School of Medicine, 1931; age 66; died May 22, 1968. Dr. McCarthy was on the staff of Kane Community Hospital and conducted several clinics in Kane for the Commonwealth. Surviving are his wife, a daughter and a brother.

○ **James C. Reed**, Montoursville; Jefferson Medical College, 1907; age 89; died June 2, 1968. Dr. Reed served as a private during the Spanish American War. He was closely associated with the Geisinger Medical Center for many years and received a fifty year plaque from Lycoming County Medical Society for service to the profession. Surviving are his daughter, two grandchildren and two great-grandchildren.

○ **Hilda G. Ruch**, Allentown; Woman's Medical College, 1946; age 64;

died June 6, 1968. Dr. Ruch had been assistant chief of pediatrics at Allentown Hospital and was medical director of the Lehigh Valley Child Development Center, Bethlehem. Surviving are his parents and a sister.

○ **James M. Surver**, Tuckahoe, N.J.; Jefferson Medical College, 1929; age 63; died June 7, 1968. Dr. Surver was a professor of tumor surgery at Jefferson. Surviving are his wife and stepson.

○ **Thomas A. Williams, Jr.**, Philadelphia; Howard University College of Medicine, 1926; age 73; died June 6, 1968. Dr. Williams is survived by his wife and four sisters.

○ **Russell G. Witman**, Swarthmore; Temple University School of Medicine, 1915; age 82; died May 31, 1968. Dr. Witman was a past-president of the medical staff of Taylor Hospital, Ridley Park and a veteran of World War I. Surviving are his wife, a son, three grandchildren and four great-grandchildren.

John J. Blasko, Washington, D.C.; St. Louis University School of Medicine, 1935; age 56; died July 2, 1968. Dr. Blasko was certified by the American Board of Psychiatry and Neurology and was certified as a Mental Hospital Administrator by the American Psychiatric Association. From 1962 until his retirement in June 1968 he was director of the Veterans' Administration Psychiatry, Neurology and Psychology Service. Surviving are his wife and a son.

Stanford W. Mulholland, St. Croix, V. I.; University of Michigan School of Medicine, 1925; age 66; died June 28, 1968. Dr. Mulholland was a former professor of urology at Woman's Medical College. His wife, two daughters and a son survive.

Francis A. Riley, Wayne; Georgetown University School of Medicine, 1928; age 65; died June 22, 1968. Dr. Riley was a retired U.S. Public Health Service physician and had served in World War II. Surviving are his wife, two daughters and three grandchildren.

Abraham J. Rosenfeld, Philadelphia; age 60; died June 22, 1968. Surviving are his wife, two sons, a daughter, two sisters and a brother.



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects
intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.



Parepectolin[®]

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid
ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls
three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.



PENNSYLVANIA
MEDICINE

meetings

AUGUST

Eighth International Congress of Gerontology, August 24-29, 1968, Sheraton Park and Shoreham Hotels, Washington, D.C. and Baltimore, Maryland.

SEPTEMBER

Niuth International Congress of Neurology and the Fourth International Congress of Neurological Surgery, September 20-27, 1968, New York City.

PMS Board Meeting, September 25, 1968, Pittsburgh Hilton Hotel.

PMS House of Delegates, September 26-29, 1968, Pittsburgh Hilton Hotel.

Annual Fall Meeting of the Pennsylvania Chapter of the American Academy of Pediatrics, September 21-22, 1968, Allenberry-on-the-Yellow Breeches, Boiling Springs.

Sixth National Cancer Conference for physicians and allied scientists, September 18-20, 1968, Denver Hilton Hotel, Denver.

International College of Surgeons Congress (four meetings) beginning September 28, 1968 in Honolulu, Hawaii.

OCTOBER

PMS Annual Scientific Sessions, October 27-29, 1968, Chatham Center, Pittsburgh.

Annual Session, American Society of Anesthesiologists, October 19-23, 1968, Washington, D.C.

Second National Congress on Medical Ethics, AMA Judicial Council, October 5-6, 1968, Drake Hotel, Chicago.

37th Annual Meeting, American Academy of Pediatrics, October 19-24, 1968, Chicago.

Tenth International Congress on Diseases of the Chest, October 4-8, 1968, Washington Hilton Hotel, Washington, D.C.

75th Convention, Association of Military Surgeons, October 21-23, 1968, Sheraton Park Hotel, Washington, D.C.

33rd Annual Meeting, Industrial Hygiene Foundation, October 15-16, 1968, Chatham Center, Pittsburgh.

American College of Obstetricians and Gynecologists District Meeting, October 17-19, 1968, Bellevue-Stratford Hotel, Philadelphia; October 16-18, 1968, Pittsburgh-Hilton Hotel, Pittsburgh.

Eleventh Congress, Pan-Pacific Surgical Association, October 14-22, 1968, Honolulu, Hawaii.

Annual Clinical Congress, American College of Surgeons, October 21-25, Atlantic City, N.J.

PENNSYLVANIA MEDICINE



PENNSYLVANIA
MEDICINE

write now

Booklets: *Humanizing the City*, 25c from Public Affairs Pamphlets, 381 Park Avenue South, New York, N.Y. 10016. . . *Poverty and the Ghetto at the Heart of Despair and Civil Disorder*, free of charge from the Family Service Association of America, c/o Alfred V. Taylor, 44 E. 23rd Street, New York, N.Y. 10010. . . *The Artificial Kidney, Heat Transfer—Seattle, Rotary Positive Displacement Pumps, and Protective Coatings for the Nuclear Industry*, review copies on request from the American Institute of Chemical Engineers, 345 East 47th Street, New York, N.Y. 10017. . . *Thinking About Drinking*, 20c from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. . . *Legal Aspects of PHS Medical Care—A Programmed Instruction Course*, available from the U. S. Government Printing Office, Washington, D.C. 20402 at 55c for the programmed instruction manual and 50c for the related reference booklet. . . *Catalogue of Films on Mental Retardation*, available free on request from the RSA Information Service, Social and Rehabilitation Service, U. S. Department of HEW, Washington, D.C. 20201.

Pamphlet: *Determination of Need for Medical Evaluation in Driver Licensing*, individual copies available from the Committee on Medical Aspects of Automotive Safety, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

To fight TB- find it first!

Make tuberculin testing routine
with every physical examination.



TUBERCULIN_(Rosenthal) TINE TEST

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



830-8/6135

TEMPLE UNIVERSITY HEALTH SCIENCES CENTER

presents the 12th annual postgraduate course

RECENT ADVANCES IN MEDICINE

on 8 consecutive Wednesdays

from October 16th to December 4th, 1968,

from 11:00 a.m. to 4:00 p.m.

Aims of Course: Problems in Clinical Practice

Methods: Grand rounds, clinics, case discussions, office procedures, lectures and panel discussions, all with audience participation.

Faculty: Members of the Department of Medicine and other selected Departments of Temple University Health Sciences Center: Dr. Carl V. Moore, Washington University, St. Louis, Missouri and Dr. Donald C. Seldin, University of Texas, and other distinguished physicians from other medical schools.

For Further Information and Curriculum

DEPARTMENT OF MEDICINE

Temple University Health Sciences Center

3400 N. Broad Street

Philadelphia, Pennsylvania 19140

SOL SHERRY, M.D.

Chairman, Department of Medicine

ALBERT J. FINESTONE, M.D.

Director of Course

The Seventh Annual Dickinson Forum

Offers

THE FIRST COURSE BY THE
PENNSYLVANIA BAR INSTITUTE IN

MEDICAL MALPRACTICE

Friday & Saturday
August 23 & 24, 1968

Holland Union, Dickinson College
Carlisle

Pennsylvania Physicians are cordially
invited to attend.

For information regarding the course
schedule and registration, contact:

PENNSYLVANIA BAR INSTITUTE

Post Office Box 425

Harrisburg, Pa. 17108

Phone: (717) 233-5774



PHYSICIANS WANTED

Attention: Physicians wishing to relocate and young physicians wishing to establish a rewarding practice in general medicine, internal medicine, obstetrics, gynecology, pediatrics, surgery, contact: A. W. MAYER, Administrator, The Titusville Hospital, Titusville, Pa. (814) 822-2291.

Physicians—part or full time. Student and Employee Health Service. Medical School hospital affiliation. Faculty appointment. Salary commensurate with qualifications. Submit curriculum vitae. P-31, P. O. Box 2066, Philadelphia, Pa. 19103. An equal opportunity employer.

Physician Wanted: Excellent opportunity for general practitioner, Emporium, Pa. County seat in northern area of State, center of hunting and fishing. Prosperous community, diversified industry, modern hospital facilities available. GP with large active practice retired, offices available. Contact EMPORIUM CHAMBER OF COMMERCE, 105 E. Fourth St., Emporium, Pa. 15834.

General Practitioner: Urgently needed. Community located in Northwest Pennsylvania. Population 6,200, drawing capacity 20,000. Fully accredited 70-bed hospital, new addition to be added. Eight miles from beautiful Kinzua Dam Recreational Area. Contact ADMINISTRATOR, Community Hospital, Kane, Pa. 16735.

House Physicians—Limited openings for house officers available. Salary \$18,000 per year. 274-bed accredited general hospital. Must be eligible for or have licensure in Pennsylvania. Write: OFFICE OF ADMINISTRATOR, Lower Bucks Hospital, Bristol, Pa. 19007.

GP and internist needed by expanding seven-man group; practice in city of 12,000 with a trade area in excess of 50,000; 90 miles from Minneapolis and St. Paul; excellent schools, including State Junior College; center of vacation area of many lakes; winter ski facilities 30 minute drive; 18-hole golf course, grass greens; 100-bed approved, expanding hospital with resident pathologist and three radiologists; 30 days annual vacation; time off for

study; good salary first year, then full partnership. If you are tired of the pressures of the big cities and if this interests you for present or future planning, write to: THE WILLMAR CLINIC, Willmar, Minnesota 56201.

House physician for 202-bed general hospital, located in a growing university community, 55 miles from Pittsburgh. Rotate services with other house physicians. Pennsylvania license required. An excellent introduction to a community with good practice opportunities. Contact ADMINISTRATOR, Indiana Hospital, Indiana, Pa. 15701.

Wanted: Full time industrial physicians for permanent employment in du Pont Company plants in various states. Career positions. Excellent opportunity. General practitioners preferred. Salary open. Immediate openings. An equal opportunity employer—male/female. Call collect or write to: C. A. d'ALONZO, M.D., Medical Director, E. I. du Pont de Nemours and Company, 11400 Nemours Building, Wilmington, Delaware 19898, (302) 774-6234.

Grove City Area—physicians needed, specialists or G.P.s. Drawing population 20,000. Have no ophthalmologist, orthopedist, urologist, Ob-gyn, pediatrician, internist. Have one general surgeon. Need G.P.s also. Bids being accepted to build new medical offices immediately adjacent to hospital. No limit on number. Nearest hospital to intersection of interstate 79 and 80. Rt. 80 complete in 1970. The expansion of Grove City College

and Slippery Rock State College has already made its impact felt. Hunting, fishing, boating, 15 minutes away. Contact Richard McLachlan, M.D., Grove City Hospital, Grove City, Pa. 16127.

Emergency Room physicians needed for full-time staffing. Ideal for the new graduate or for the experienced physician wishing to slow down. Write ADMINISTRATOR, Sharon General Hospital, Sharon, Pa.

Psychiatrist—full-time 700-bed hospital containing two geographic units and geriatrics-infirmity unit. Community oriented program. Located six miles from downtown Pittsburgh, medical school, psychiatric and analytic institute. Opportunities exist for faculty appointment, personal analysis or analytic training. Pennsylvania licensure required or eligibility for licensure. Requirements: two years experience and completion of three years residency—\$17,839-\$20,629. Completion of three years residency only—\$16,170-\$18,725. Write SUPERINTENDENT, Dixmont State Hospital, Glenfield, Pa. 15115.

Orthopaedic Surgeon wanted—Associate for well established orthopaedic clinic in Eastern Pennsylvania. Under 34 years. Partnership after 1½ years. No investment needed. Board eligibility required. Write Department 513, PENNSYLVANIA MEDICINE.

Internists, general practitioners, radiologists wanted to group medical practice in inter-city Philadelphia. Prefer those interested in social change. Competitive salary, fringe benefits and

CLASSIFIED ADVERTISING INFORMATION

RATES—\$10.00 per insertion up to 30 words; 40 cents each additional word; \$1.00 per insertion for answers sent in care of Pennsylvania Medical Society. Payable in advance.

COPY DEADLINE—Copy due by the first day of month preceding month of publication. Send to Pennsylvania Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pennsylvania 17043. The right is reserved to reject or modify copy to conform with publication rules.

DEPARTMENT NUMBERS—Advertisers using department numbers forbid disclosure of their identity. Written inquiries are forwarded to such advertisers.

WORD COUNT—Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one, and "Write Department . . ., Pennsylvania Medicine," as five.

classified

faculty appointment to medical school for qualified physicians. Please contact DR. HALE COOK, 3450 North 17th Street, Philadelphia, Pa. 19140.

Internist or Generalist—interested in industrial medicine—full-time preferred but part-time will be considered. Some administration depending on position. Openings due to imminent retirements at Cleveland, Pittsburgh, Detroit, Philadelphia. Large multi-state industry. Full-time salaried positions \$18,000-\$20,000 to start with excellent fringe benefits. Part-time salaried positions available at same locations. \$10,000 with fringe benefits. Equal opportunity employer. Reply with medical resume to DEPARTMENT 530, PENNSYLVANIA MEDICINE.

House Physicians (3)—needed at 235-bed JCAH accredited short-term, general hospital in suburban Phila. Established educational program and residency in general surgery. \$13,500 per annum plus benefits. Excellent practice opportunity in growing area. Pa. License required. Contact: BRUCE R. MARGER, M.D., Sacred Heart Hospital, 1430 DeKalb St., Norristown, Pa. 19401.

Young G.P. Partnership—desires to add third man. Solo practice opportunities also available. Small town, excellent environment for raising family.

New high school. 130-bed hospital. Challenging inpatient service averaging 25 to 30 patients. OB optional. College, industry, nursing home, school, and emergency room work available, plus guaranteed busy office practice. Visit at our expense. Contact GORDON R. JONES, M.D., Greene County Memorial Hospital, Waynesburg, Pa. 15370. Phone (412) 627-3101.

Internist, boarded or eligible, needed to establish own practice. Registered Pa. Service area 65,000. Two other internists. Appointment available 207-bed JCAH approved modern hospital. All services covered by specialists. Communicate ADMINISTRATOR, Lewistown Hospital, Lewistown, Pa. 17044.

Cardiologist—To be available immediately, Charleroi-Monessen Hospital, North Charleroi, Pa., 15022. Must be Board certified or Board eligible in cardiology, or must be Board certified or Board eligible in internal medicine with at least one additional year of formal training in cardiology. Primary duties to serve as chief of the department of cardiology and director of the coronary intensive care unit presently under development. Hospital consists of 211 beds plus 24 bassinets and is in a developmental expansion program.

The present volume of electrocardiograms is 4,500 per year. Terms open. The hospital will defray up to 1/2 the expense for personal interview. Direct all responses to the Administrator.

PRACTICE AVAILABLE

General Practice—for sale, Central Bucks County, Pa., active, acute, no OB, good coverage, open staffed hospitals, excellent gross, will introduce, inquiries invited. DANIEL A. NESI, M.D., 202 N. Main St., Chalfont, Pa. 18914.

Established Family Practice—available now. Excellent coverage and hospitals. Along Keystone Shortway. Inquiries invited. Contact: W. W. WILLARD, M.D., 33 West Southern Ave., South Williamsport, Pa. (717) 323-7994.

OFFICES AVAILABLE

General Practitioners—Rent-free air conditioned offices for first year. Centrally located with adequate parking. Beautiful resort area in southcentral Pennsylvania. Bedford offers an excellent practice opportunity. Small town; friendly surroundings with no big city problems. Write giving all particulars to P.O. Box 162; Bedford, Pa. 15522.

PHYSICIAN PLACEMENT SERVICE

SITUATIONS WANTED

Pediatrics—Several board certified or board eligible pediatricians seeking opportunities to practice in areas of need. Types of practice and locations preferred vary. Names and addresses on request from PHYSICIAN PLACEMENT SERVICE, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Obstetrics and Gynecology—Eight M.D.s board certified or board eligible in OB-GYN seek immediate placement in Pennsylvania. Types of practices and lo-

cations preferred vary. For complete listing contact PHYSICIAN PLACEMENT SERVICE, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Surgeons—Some board certified, others board eligible, seeking opportunities to practice general surgery, neurosurgery, orthopedic surgery, thoracic cardiovascular surgery in solo, partnership, group, etc. List on request from PHYSICIAN PLACEMENT SERVICE, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Internists—Board certified or board eligible, seek opportunities in solo, partnership, group practices. For complete listing contact PHYSICIAN PLACEMENT SERVICE, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Pennsylvania Medical Society offers assistance through its Placement Service for physicians seeking locations as well as communities seeking additional medical coverage. There are registrations in most specialties and general practice. List of physicians in various specialties available on request. Communities seeking general practitioners are requested to list with the Service.

For further information, contact Physician Placement Service, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.



Vacation trip....

Motion sickness?



This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate
solution
emesis control

*When the problem
is only skin deep*

USE 'POLYSPORIN'® POLYMYXIN B-BACITRACIN OINTMENT

for topical antibiotic therapy with minimum
risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in 1/2 oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.





Open Letter to Blue Shield

Dear Sir:

For a long time now, we have all looked to Blue Shield as the answer to many of our economic problems in medicine and have been grateful for all the help you have given to protect us from those who would misuse us. But recently, your representative and your letters have given me cause to wonder.

You see, for many years, we have been told that the good guys of Blue Shield who administer the "Doctor's Plan" were protecting us from intrusion into our practices by the bad guys from Washington. Now comes your letter with its implied threats as part of a series of events which gives me cause to wonder—who are the bad guys anyway?

For a number of years, I've heard my colleagues ask why Blue Shield was called the Doctor's Plan when their letters to Blue Shield were often left unanswered and their efforts to intercede in behalf of a patient were often met with less than courtesy. I have heard my colleagues ask why Blue Shield implies in their sales of individual and group contracts that Blue Shield pays the doctor bill when partial payment is the rule rather than the exception. They don't understand why Blue Shield fee schedules have lagged far behind customary fee patterns and why they must often face the wrath of Blue Shield policyholders who are often disillusioned to find that their insurance did not really cover everything. They haven't understood the inequities in payment to various specialties as listed in Blue Shield fee schedules. To all this, we have always replied that Blue Shield was providing needed care to the medically indigent who, through the regular payment of low premiums, were providing for at least a partial payment of their physician's regular fee and thus were allowed a free choice of physician. We have also replied that Blue Shield, along with our almost five billion dollar annual gift of free medical care, would help prevent intrusion into our practices by the Washington bad guys.

We were not, however, quite so quick with an answer as to why industry was allowed to use Blue Shield group plans as bargaining packages, leading to confusion of the recipients as to what they were getting, or why the low premium plans, originally intended for the medically indigent, were often peddled to moderate and high income families. We also were unable to explain why a practical method of administering the service benefit feature of the plans was lacking and why the practicing physician was

often the fall guy for the inevitable chiseler who we occasionally find quite willing to lie about his income. Frankly, we have just had to assume that Blue Shield has had more faith in human nature than does the Internal Revenue Service.

So you see, Gentlemen, I have probably been confused all along, and your letters have just made me aware of it. At any rate, your letters will help us to decide as to who is protecting whom in Pennsylvania and perhaps help us to decide which is worse, the cure or the disease. Perhaps, we can even decide who is intruding into the practice of medicine and the doctor-patient relationship.

A recent letter of yours concerns the charge of a customary fee to an active young man without dependents who is gainfully employed at a salary in excess of Blue Shield's annual limits. Your letter concerns a young man who gives the appearance of trying to connive an indigent fee because of a loophole in his Blue Shield contract and who has previously always paid the customary fee and, in the past, has also had supplementary insurance. If, then, this young man, without family obligation or dependents, represents the individual requiring service benefits, I am even more confused. My bewilderment is not helped when you tell me that Blue Shield reimbursed this patient for the full customary fee and now wants me to return the difference.

I also cannot understand why your representative tries to coerce our local collection agency into withdrawing collection procedures in Blue Shield cases and often advises patients not to pay bills in excess of your fee schedules. He seems to do this without knowledge of the patient's income. If I didn't know all along that you fellows were the good guys, I would now think that this chicanery was being used to encourage chiseling and that you were intruding into the private practice of medicine. But we all know that the intrusion into our medical practices will come from Washington and not Harrisburg. So, I'm still bewildered.

The kids say you can always tell the bad guys from the good guys by the color hats they wear; and, like I say, you have me confused. Do you suppose I could get you fellows to wear your hats?

Sincerely yours,

RALPH J. MILLER, M.D.
Indiana, Pa.

Organization and Management of Family Practice

Dear Sir:

The manual *Organization and Management of Family Practice*, prepared by the Committee on Medical Economics of the American Academy of General Practice, has so much of value for anyone engaged in family practice

that I am compelled to write this letter. For the new graduate it can be invaluable.

The philosophy of family practice is very well stated, so well in fact that I have some feeling of inadequacy as I look back on the past 20 years.

Of particular interest to me was the methodical and practical method of selection of a location to practice. For the uncommitted young doctor, it should be an aid in this most important item. In this age of computers, one wonders if selection on a properly programmed machine might give the best results. Although I think with nostalgia of the days when, by a combination of lucky circumstances, I fell into, rather than chose the right place to practice, I must admit the new ways are better. It's like comparing planned parenthood to the old hit and miss, Russian roulette method.

Organization and Management of Family Practice gives the young doctor the advantage of many years of experience of well-organized and efficient physicians. There are innumerable valuable tips; for example, in discussing office layout, the manual recommends hanging office doors so that patients are screened from view. This may seem like a small item, but it is disconcerting when you discover that unless you provide another drape or screen, patients in the waiting room may be looking down the speculum

with you if the examining room door is inadvertently opened.

Methods of financing the construction of an office, proper methods of entering a partnership, selection of office assistants with efficient interview techniques, all these and many more subjects are well covered.

Finally, the section on community resources and professional associations will help to start the young physician in the best way possible.

This is a fine manual for the recent graduate, and it can be of great help to the established physician who feels there are areas in his practice that need improving and updating.

H. C. AMACHER, M.D.
Erie, Pa.

(Editor's Note: The book may be obtained from The American Academy of General Practice, Volker Blvd. at Brookside, Kansas City, Missouri 64100.)

Tobacco Maneuver "On The Record"

Dear Sir:

During the past winter, large numbers of physicians, dentists, teachers, lawyers, and other professional persons received a reprint of an article on cigarette smoking which appeared in the January, 1968, issue of TRUE Magazine. Among those receiving this reprint, undoubtedly, were readers of your journal.

Very serious questions have been raised as to the accuracy, impartiality, and integrity of this article and its method of distribution.

On March 21, the WALL STREET JOURNAL published an article by Ronald Kessler, revealing that the reprints were sent out not by TRUE, which was the impres-

sion given, but by Tiderock Corp., a public relations firm employed by the Tobacco Institute.

I have entered the WALL STREET JOURNAL's article into the Congressional Record, along with comments by the Public Health Service and the American Cancer Society (March 27, 1968, p. S3415 et seq). The National Interagency Council on Smoking and Health has had this reprinted and informs me that copies will be furnished free upon request to the Council, at Box 3654, Central Station, Arlington, Virginia 22203.

WARREN G. MAGNUSON, Chairman
Senate Commerce Committee

Advertiser's Index

Abbott Laboratories . . .	32, 33, 34, 75, 76, 77, 78, 3rd Cover	Mead Johnson Laboratories	28, 29, 30
Ayerst Laboratories	4, 5	Medical Protective Co.	23
Bertholon-Rowland Agencies	31	The National Drug Company	24
Breon Laboratories	23	Parke, Davis & Company	38
The Brown Pharmaceutical Co.	39	Pennsylvania Bar Institute	69
Burroughs-Wellcome	72	Pennsylvania Hospital	42, 43
Campbell Soup Company	55	Poythress, Wm. P. & Co., Inc.	20
Coca Cola Company	43	Roche Laboratories	19, 4th Cover
Conal Pharmaceuticals, Inc.	25	Rorer, Wm. H., Inc.	68, 72
The Dow Chemical Company	13	Sandoz Pharmaceuticals	58
Geigy Pharmaceuticals	26, 27	Searle, G. D. & Co.	56, 57
Hynson, Westcott & Dunning	1	The Stuart Company	35
Lederle Laboratories	3, 21, 69	Temple University	69
Lilly, Eli and Company	10, 11, 12, 36, 37, 44	Warner-Chilcott Laboratories	17, 18
		Wetherhold and Metzger	66

Abbott Antihypertensive Building Blocks

A simplified approach
to the practical management
of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON[®]

METHYCLOTHIAZIDE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

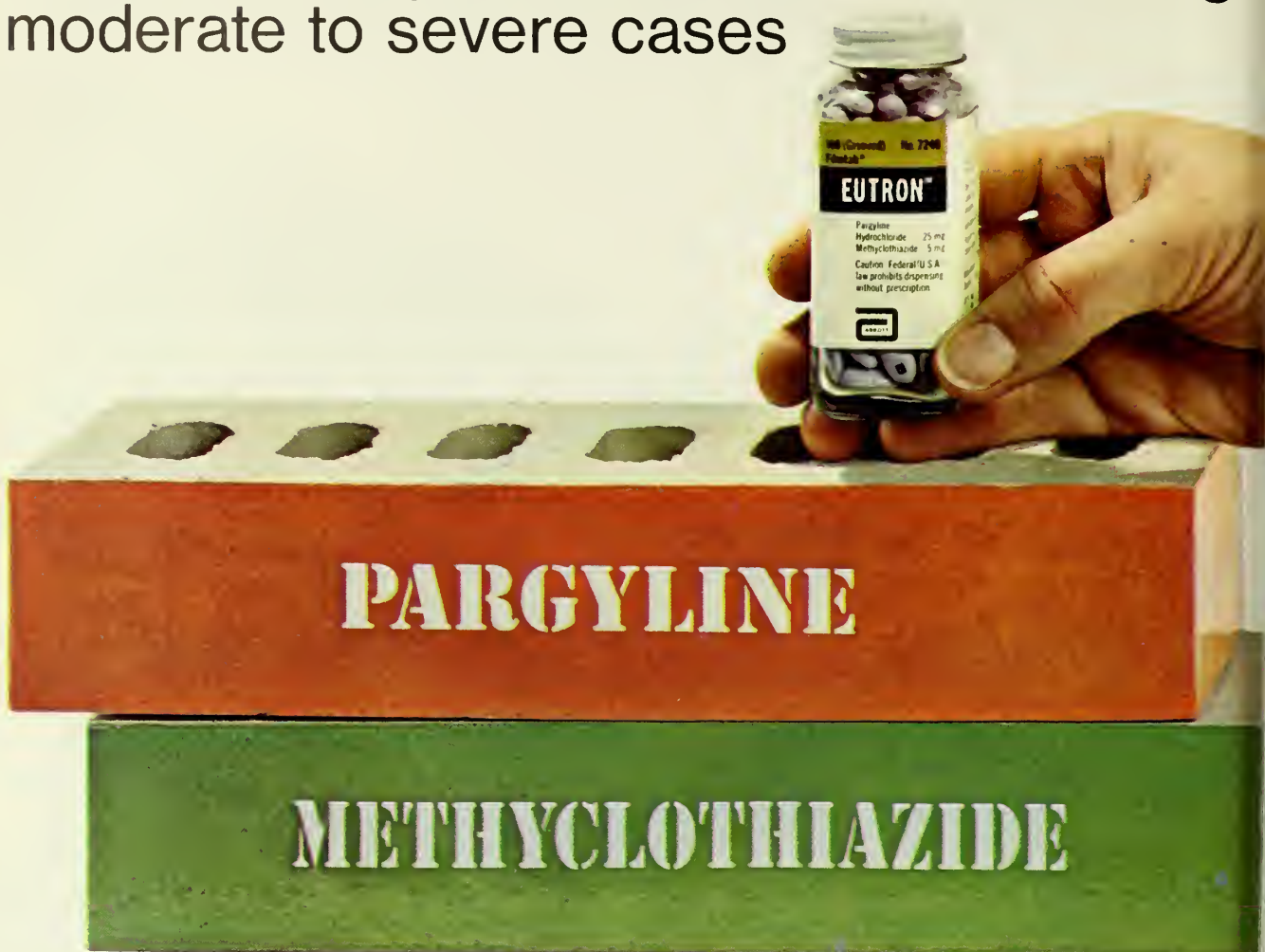
Once a day, every day
ENDURONYL[®]

METHYLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.



See Brief Summary on final page of advertisement

ENDURON[®] | ENDURONYL[®]

METHYLCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symptomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON[™] Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhib-

itors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions —Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug.

804438R



Open-eyed nights

Too tense to sleep...too tired to get up. Early to bed, late to rise, and not



much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is



generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anti-convulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and

protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.



Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Valium® (diazepam)
*useful for the relief of psychic tension,
alone or with associated depressive symptoms*

PENNSYLVANIA MEDICINE

SEPTEMBER 1968



THE FRANCIS A. COUNTRYWAY
LIBRARY OF MEDICINE
RECEIVED
10 SEP 1968

Why Continuing Education?

OFFICIAL REPORTS SUMMARY

PITUITARY STALK SECTION



Y EXCHANGE OFFICE
FRANCIS A COUNTRYWAY LIB
MED-10 SHATTUCK ST
BOSTON MASS 02115

PENNSYLVANIA
MEDICAL
SOCIETY

OCTOBER
27-28-29
1968

COMMITTEE
ON
CONVENTION
PROGRAMS

1968 *Scientific Seminars*

ELECTROLYTE
METABOLISM
AND
RENAL
DISEASES

CHATHAM
CENTER

PITTSBURGH

1968
TECHNICAL
EXHIBITS





1968 scientific seminars

pennsylvania medical society

CHATHAM CENTER, PITTSBURGH

OCTOBER 27-29

Seminars For Physicians

Theme: "Electrolyte Metabolism and Renal Diseases"

Sunday, October 27

A.M. — WATER AND SODIUM IN HEALTH AND ILLNESS

Noon — Luncheon Discussion Groups

P.M. — POTASSIUM OUTSIDE AND INSIDE CELLS

Monday, October 28

A.M. — RENAL DISORDERS: NEPHRITIS AND NEPHROSIS

Noon — Luncheon Discussion Groups

P.M. — MANAGEMENT OF URINARY INFECTIONS AND OF UREMIA

Fee: \$25.00—Members

\$35.00—Non-members

(includes luncheons)

No charge—students, residents, interns
except \$5 for each meal function.

Evening Programs

Sunday, October 27

SYMPOSIUM ON GROUP PRACTICE

Open to all physicians, including interns, residents, and students.

No Fee.

Monday, October 28

STATUS OF ORGAN TRANSPLANTATION

Open to all physicians, nurses, allied professions and the public.

No Fee.

Seminar For Nurses And Allied Professions

Monday, October 28

All Day

"Seminar on Renal Diseases" Fee: \$5.00

Fee waived for students

Specialty Societies

Scientific Sessions—Tuesday, October 29

Pa. ALLERGY Association
Pa. Chapt., American College of CHEST PHYSICIANS
Pittsburgh Academy of DERMATOLOGY
Pa. Society of INTERNAL MEDICINE
Mid-Atlantic NEUROSURGICAL Society
Pa. Acad. of OPHTHALMOLOGY & OTOLARYNGOLOGY
Pa. ORTHOPAEDIC Society
Pa. Acad. of PHYSICAL MEDICINE & REHABILITATION
Pittsburgh PROCTOLOGIC Society
Pa. PSYCHIATRIC Society

Other Meetings—Various Times

Pa. Assoc. of CLINICAL PATHOLOGISTS
Pa. RADIOLOGICAL Society
UROLOGICAL Assoc. of Pa., Inc.

Alumni Activities

Temple Univ. — Reception — 6 P.M., Sunday, October 27
Jefferson—Dinner—Monday, October 28
(more details to be announced later)

For further information write:

Committee on Convention Program, Pennsylvania Medical Society
Taylor Bypass & Erford Road, Lemoyne, Pennsylvania 17043

first solely scientific convention SPONSORED BY THE pennsylvania medical society



PENNSYLVANIA
MEDICINE

/medigram

SEPTEMBER, 1968

ASSOCIATE EDITOR APPOINTED

In order to provide more professional cooperation with the Managing Editor of "Pennsylvania Medicine" and to improve the medical editorial coverage in the Journal, David Smith, M.D., chief of medical service, Harrisburg Polyclinic Hospital, has been appointed by the PMS Board of Trustees and Councilors as Associate Medical Editor.

EMERGENCY SERVICES MERGER PENDING

The PMS Board of Trustees has approved a recommendation that all aspects of emergency medical services be merged under the Council on Scientific Advancement and the matter will face final action at the meeting of the House of Delegates. Currently, disaster medical care is a responsibility of the Council on Public Service and the emergency medical aspects of highway safety, plus other facets, are handled by the Council on Scientific Advancement.

TWO WORKSHOPS SET

County society medicine and religion chairmen in western Pennsylvania are invited to an expense-paid workshop on Tuesday, October 29, in conjunction with the 1968 scientific seminars of the Pennsylvania Medical Society in Chatham Center, Pittsburgh. On Wednesday and Thursday, November 13 and 14, a two-day intensive training session for members of the PMS Speakers' Bureau will be held in the State Society headquarters building. In addition to Speakers' Bureau members, PMS officers will be invited to participate.

MALPRACTICE COVERAGE PROBE CONTINUES

Two recommendations were made by the PMS Board of Trustees at its last meeting regarding malpractice coverage. First, it authorized the sending of a questionnaire to all members to obtain the information essential to further exploration of group malpractice coverage. The Council on Medical Service has been meeting with insurance companies to devise a group plan that may have significant advantages. The Council was directed to continue its search for the best solution.

TV MATERIALS IN PROGRESS

The State Society is writing, directing and producing a variety of public service materials for use on Pennsylvania television stations, including one now in production stage on Halloween safety aspects. The material ranges from 20-second color slides and scripts to color sound-on-film one-minute announcements.

MEDICINE-RELIGION COURSE SUCCESSFUL

The pilot course on "Counseling the Troubled Person", developed and presented by the PMS Committee on Medicine and Religion, has been completed with seven physicians and sixteen clergymen enrolled in the eight weekly sessions. The initial course was held at York. Evaluations by the registrants indicated the course was excellent and useful and that such a course should be presented throughout the state. The Committee is reviewing the course data and will consider plans to present the course in other communities.

SCIENTIFIC PROGRAM PLANS SET

The PMS scientific meeting, separate this year from the business session, is in readiness for what is hoped will be a record number of participants for the three-day teaching meeting in Pittsburgh's Chatham Center, October 27-29. The program is built around electrolyte metabolism and renal disease and will include a public program on organ transplants, specialty society meetings and alumni dinners and receptions.

PMS HOUSE PREPARES TO MEET

Medicine's course in Pennsylvania will get new pilots and new directions the week of September 22 as 210 county society delegates to the PMS House of Delegates gather in the Pittsburgh Hilton Hotel to elect officers, hold reference committee hearings and consider reports, recommendations and resolutions. The opening session of the House will be Thursday evening with John H. Harris, Sr., M.D., President and George E. Farrar, Jr., M.D., President-Elect, presenting addresses and recommendations. The annual State Dinner will be held Saturday evening. There are indications that the House may conclude its deliberations Saturday afternoon. The Woman's Auxiliary Convention will run concurrently, as will the Physician's Art Association exhibition.

NEXT MONTH

OCCIPITAL NEURALGIA

Intractable cervico-occipital neuralgia has a multiple etiology and every effort should be made to find the cause by appropriate medical diagnostic studies.

APPALACHIA HELPS BUILD MEDICAL FACILITIES

Construction funds from the Appalachia Regional Development Program are helping Pennsylvania communities build and expand hospitals and related facilities.

21st Annual

STATE DINNER

• Programme •

Reception

Dinner

Dancing and Entertainment

Installation of George E. Farrar, Jr., M.D.
as the 119th President of the Pennsylvania
Medical Society.

Presentation of Past President's Medallion to
John H. Harris, Sr., M.D., 118th President.



Please reserve _____ tickets at \$12.00 per person for the Reception and Annual State Dinner Dance.

NAME (Please Print) _____

ADDRESS _____

CITY _____ (COUNTY SOCIETY) _____

(Please make checks payable to PENNSYLVANIA MEDICAL SOCIETY)

Lutrexin[®]

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

**IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF
PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION**

■ LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.

■ Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

■ Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting
uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC.



BALTIMORE, MARYLAND 21201

(LTR23)

PENNSYLVANIA MEDICINE®

© 1968 Pennsylvania Medical Society

The Pennsylvania Medical Journal
Official Publication of the Pennsylvania Medical Society

SEPTEMBER, 1968

VOLUME 71, NUMBER 9

FEATURES

- The Tiny Flaws in Medical Design Can Kill 76
Why Continuing Education? 115

ORIGINAL PAPERS

- Toxicology in the Emergency Room 51
Pituitary Stalk Section 53
Suicide with Amitriptyline-Perphenazine Combination .. 71
Short-Term Treatment of Acute Bursitis of the Shoulder 66
Future Trends in Stroke Management 72
Muscular Overuse and Serum Creatine
Phosphokinase (CPK) 74

NEWSFRONTS

- Montgomery County Rush Award Presented 7
PMS Advises on Paper Mill Dilemma 8
York Hospital Leads in Medical Care Study 10
Close-up/M.D.s 26
Capitol Report 33
Correspondence 36

EDITORIAL

- Involvement vs. Confusion 48

SCIENTIFIC REPORTS

- Cardiovascular Briefs 118
Cancer Forum 129

GENERAL

- Annual Report Summaries 87
Continuing Education 126
Obituaries 133
Meetings 134
Write Now 135
Classified 136
In My Opinion 139

PUBLISHED MONTHLY BY THE
PENNSYLVANIA MEDICAL SOCIETY
TAYLOR BYPASS AND ERFORD ROAD,
LEMOYNE, PENNSYLVANIA 17043

Subscription \$5.00 Single Copy 50¢

PUBLICATION COMMITTEE

Joseph A. Walsh, M.D., Blakely-Olyphant
Chairman
D. George Bloom, M.D., Johnstown
H. Thompson Dale, M.D., State College
William J. Kelly, M.D., Pittsburgh
Robert S. Sanford, M.D., Mansfield

STAFF

Carl B. Lechner, M.D., 4111 Beech Avenue,
Erie 16508—Medical Editor
Thomas J. McCaghren, Taylor Bypass and
Erford Road, Lemoyne 17043—Man-
aging Editor
Claudia Helsel, Taylor Bypass and Er-
ford Road, Lemoyne 17043—Editorial
Assistant

CONTRIBUTING EDITORS

Harry E. Bacon, M.D., Philadelphia
William C. Beck, M.D., Sayre
Walter I. Buchert, M.D., Danville
Lewis T. Buckman, M.D., Wilkes-Barre
A. Reynolds Crane, M.D., Philadelphia
Garfield G. Duncan, M.D., Philadelphia
Mario N. Fabi, M.D., Scranton
George H. Fetterman, M.D., Pittsburgh
Wendell B. Gordon, M.D., Pittsburgh
Samuel B. Hadden, M.D., Philadelphia
Jack D. Myers, M.D., Pittsburgh
Thomas F. Nealon, Jr., M.D., Philadelphia
Eugene P. Pendergrass, M.D., Philadelphia
Mary DeWitt Pettit, M.D., Philadelphia
Sydney E. Sinclair, M.D., Camp Hill
David A. Smith, M.D., Harrisburg
James R. Watson, M.D., Pittsburgh

• **GENERAL.** Established 1897. Penn-
sylvania Medicine may not be held re-
sponsible for opinions expressed in any
of its contents.

• **EDITORIAL.** Address all original
papers, features, and editorial corre-
spondence to the Managing Editor.

• **ADVERTISING.** Pennsylvania Medi-
cine's advertising policy conforms with
principles governing advertising in
American Medical Association scientific
publications. National advertising rep-
resentatives: State Medical Journal Ad-
vertising Bureau, Inc., 510 North Dear-
born Street, Chicago, Illinois 60610.
Advertising rates on request to Penn-
sylvania Medicine office, Taylor Bypass
and Erford Road, Lemoyne, Pennsylvania
17043, or the SMJAB. For classified
rates, see classified section.

• **MAILING.** Second-class postage paid
at Lemoyne, Pennsylvania.

• **CHANGE OF ADDRESS.** Give name,
old address, new address (include ZIP
number), state if change is permanent
or temporary. Send notice to Penn-
sylvania Medicine, Taylor Bypass and Er-
ford Road, Lemoyne, Pennsylvania
17043. Allow six weeks for change of
address.

THE FRANCIS A. COUNTRYWAY
LIBRARY OF MEDICINE
BOSTON
10 SEP 1968

When it's more than a bad cold



**your patient can feel better
while she's getting better**

Achrocidin[®]

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN[®] Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and

may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



C49-B

Do you have patients
who try to hide anguish
behind arrogance?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you.

Whether depression is open or secretive, Aventyl HCl assists you in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.



Eli Lilly and Company, Indianapolis, Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline
Hydrochloride

800315

(See last page for prescribing information.)



At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl® HCl (nortriptyline hydrochloride, Lilly) under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl

HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl® HCl (nortriptyline hydrochloride, Lilly) is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily

10 mg.—Ages three to six, 1 Pulvule one to three times daily

Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily

Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid, 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500. [101267]

Additional information available to physicians upon request.



Eli Lilly and Company
Indianapolis, Indiana 46206



Aventyl® HCl

Nortriptyline Hydrochloride

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two months after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.



newsfronts



Left to right: Robert E. Glendening, Manager of Advertising and Sales Promotion for the Atlantic Richfield Company; John Carlton, recipient of the Montgomery County Benjamin Rush Award; and Elwin S. Carlin, M.D., President of the Montgomery County Medical Society.

Beyond the Call of Duty

Helicopter Traffic Reporter Wins Montgomery County '68 Benjamin Rush Award

The Montgomery County Medical Society has named helicopter traffic reporter John Carlton the winner of its 1968 Benjamin Rush Award.

Hovering over the busy highways leading in and out of Philadelphia, Carlton reports on traffic conditions

each morning and evening during commuting rush hours. Over the past seven years, Carlton's voice and traffic reports have become a household byword in virtually every car in the Delaware Valley of Pennsylvania.

In presenting the award, Elwin S.

Carlin, M.D., the county society's president, stated that Carlton's reports have contributed greatly to the health and safety of the residents of the area.

Dr. Carlin also remarked that providing these reports is not without its dangerous aspects. Many times over the past years, Carlton and his pilot have skirted disaster and death in the performance of their daily routine.

Dr. Carlin related an account of a fire which took place at the Normandie Retirement Club in Philadelphia. The club, a home for aged residents, caught fire early one morning. Carlton and his pilot spotted smoke issuing from the building and alerted motorists to the fire situation in order that they might avoid the traffic congestion.

Realizing that many aged people might not be alerted in time to escape, the helicopter team landed their craft on the roof of the building and proceeded to crawl in the heat and smoke through the top three floors of the building waking residents and leading them to the elevator where they were carried to safety. In many instances, the residents did not respond to a knock on their doors and it was necessary to break the doors down.

When they had made certain that the top three floors were clear of people, Carlton and his pilot, both suffering from the heat and smoke inhalation, returned to the roof, their helicopter and their job to report on traffic conditions and the fire.

Named as the 1968 Group Benjamin Rush winner was the Atlantic Richfield Company, sponsor of Carlton's "Go-Patrol" helicopter service.

In Doctor Carlin's words: "... have shown that their interest in the health and safety of the area residents is not confined to the commercial aspects of sponsoring the Go-Patrol but through their financial support and company policies, have permitted Carlton and his crew to contribute in much more direct ways to the health and safety of the area residents."

County Secretaries View PMS Operations



PMS staff member Robert Lamb discusses Council on Public Service health education activities with Ulysses E. Watson, M.D.

In 1965, the Board of Trustees and Councilors of the Pennsylvania Medical Society directed that a program be started to provide secretaries of county medical societies with information on how the State Society might assist them in meeting their responsibilities.

The program involves a day-long working visit to the PMS headquarters office. Initially, the orientation program was directed at new secretaries of county medical societies. Because it has met with such enthusiastic response from those who have participated, the program was expanded to include the more experienced secretaries.

Edward A. Agnew, M.D., new Secretary of the Berks County Medical Society and Ulysses E. Watson, M.D., Secretary of the Montgomery County Medical Society are among the more recent county medical society visitors participating in the PMS orientation program.



Edward A. Agnew, M.D. and PMS staff member Charles Appleby examine a Monitor produced by operator Horace Hargrove.

Less Confering, More Doctoring

PMS Advises on "Papermill" Dilemma

The efficient utilization of physician manpower—getting physician members of hospital staffs out of the papermill, away from the conference tables and back into the practice of medicine—is a fast-growing problem under attack by the Pennsylvania Medical Society Council on Scientific Advancement.

In December of last year, at the request of the Medical Society Board of Trustees, the Council, chaired by Raymond C. Grandon, M.D., sent a copy of an AMA report dealing with attendance at hospital staff meetings to all Commonwealth hospitals.

Repeating the action, the Council sent a copy of the same report to presidents and secretaries of hospital staffs, medical directors, and administrators to show the existing flexibility in the Joint Commission on Accreditation of Hospitals requirements in regard to medical staff meetings. Specific attention was

called to statements on scientific papers and relief for physicians with multiple staff appointments.

Following are excerpts from the AMA House of Delegates June 1966 report on hospital staff meetings:

The Joint Commission on Accreditation of Hospitals in its "Standards for Hospital Accreditation" and the "Explanatory Supplement" states:

"... meetings of the medical staff are required to review, analyze and evaluate the clinical work of its members."

"... Meetings are held for the purpose of reviewing the medical care of patients within the hospital and those recently discharged and not the presentation of scientific papers or discussions."

"... this includes consideration of selected deaths, unimproved cases, infection, complications, errors in diagnosis, and

results of treatment, and review of transfusions."

"This method adopted to insure adequate evaluation of clinical practice in the hospital shall be determined by the medical staff . . . Any one of the following three methods will fulfill this requirement:

"1) Monthly meetings of the Active Staff.

"2) Monthly departmental conference . . .

"3) Monthly meetings of the Medical Records and Tissue Committees . . ."

Where there are monthly meetings of the departments or tissue and medical records committees plus utilization review committee meetings as necessary, the JCAH recommends at least quarterly meetings of the medical staff. The burden of even such quarterly meetings can be minimized, however, by holding medical staff meetings of several hospitals concurrently.

Gift After Death

Pennsylvanians whose religious beliefs do not preclude it have an opportunity—and perhaps even an obligation—to serve mankind after death by willing their bodies for scientific use.

Such unselfish gifts are handled by the State Anatomical Board which supplies the needs of the state's medical and osteopathic schools in the education of medical students.

All that is required is a paragraph in the deceased's will and, under current law, the consent of his next of kin. Further details and suggested wording for the paragraph in the will can be obtained from John F. Huber,

Council District Meetings Set

Ten councilor district meetings have been scheduled during the 119th Annual Session of the Pennsylvania Medical Society in Pittsburgh on Thursday, Sept. 26, from 3:00 p.m. to 5:00 p.m. at the Hilton Hotel.

Meetings scheduled are as follows: District 2—King's Gardens Room; District 3—Ballroom 1; District 4—Traders Room C; District 5—King's Terrace; District 6—Brigade G; District 7—Black Diamond F; District 8—Ballroom 3; District 9—Brigade H; District 11—Room 414 and District 12—Room 709.

M.D., Secretary of the State Anatomical Board, at 257 South 16th Street, Philadelphia, Pennsylvania 19103. Those who choose may even will their bodies to a specific medical school.

After death, a local undertaker designated by the Board transports the body to the medical school. After the scientific studies are completed, the remains are cremated and the ashes are joined with the ashes of others who also chose to serve mankind after death and then are buried in a grave marked with the names of the individuals while a clergyman conducts interment services. There are no post-death costs to the relatives of the deceased person.

Geisinger Surgeon Honored



FOSS MEMORIAL LECTURE—Harold Zintell, M.D., (second from right), clinical professor of Surgery at Columbia University College of Physicians and Surgeons and director of Surgery at St. Luke's Hospital Center, presented the first Harold L. Foss Memorial Lecture, established as a tribute to the late Dr. Foss, first surgeon-in-chief and superintendent of the George F. Geisinger Memorial Hospital, now The Geisinger Medical Center. Shown with him are: William T. Barnes, M.D., chairman of the Lecture Planning Committee; Mrs. Harold L. Foss; and Leonard F. Bush, M.D., chief of staff. Dr. Foss was president of the American College of Surgeons in 1952 and directed the development of the Danville institution from a small country hospital into one of the major medical complexes in the East. Dr. Bush succeeded Dr. Foss as chief of staff in 1958.

Centennarian Award Presented



The Pennsylvania Medical Society Centennarian Award is presented to Miss Jane Kenedy by James A. Collins, M.D., Secretary of Montour County Medical Society during festivities held at the Danville State Hospital.

York Hospital Leads Nation In Medical Care Study

York Hospital began the nation's first complete in-depth study and systematic evaluation of medical care last month with a \$32,800 grant awarded by the Maryland Regional Medical Program to carry out the initial planning of the study. York Hospital is a teaching affiliate of the University of Maryland College of Medicine.

The study will deal with the relationship of the hospital to the community and the delivery of medical care by physicians and the hospital. Its main purpose is to evaluate and identify subject matter for continuing education of physicians and other health professionals.

According to Robert L. Evans, M.D., director of medical education, "With the changes that have taken place in social legislation over the past several years, there has been an increasing interest and a demonstrated need for some method of systematically studying medical care delivery."

In affirming the need, Dr. Evans explained, "In short, there is an overriding need for information about how our present system of care operates and how it may be made more efficient. Then we must learn how to apply this information to producing continuing education from its present 'by guess and by God' program structure to a structure built on a foundation of identified and measured need."

The greater York area was selected as the testing ground because of its stable medical, economic and social system. The population growth rate remains constant, and few families leave the area. "These features provide an ideal place to study medical care systems and continuing education of health care personnel . . . in an area not overwhelmed by outside influence," said Dr. Evans.

He said that this area bears a very close resemblance to many communities within the Maryland region. "The data gathered in York would be applicable to the total Maryland Regional area and would serve to provide important knowledge not presently available in the greater Pennsylvania-Maryland region or in the whole nation," Dr. Evans commented.

Another ideal factor for this study in York is the availability of eight years of computerized patient records. "In effect, the health care records of 250,000 people are available in computer listing and on microfilm," he said.

This form of information storage will assure patients and physicians that they will not be identified, but the information is readily available for study groups.

From 1960 through 1964 York Hospital was the site of an in-depth study of graduate and continuing education, during which all facets of the effects of the educational program on patient care and physician function were studied. Complete financial surveys, care quality audits and psychiatric interviews were done each year. All of this data is available to match with computerized records, so that the complete past . . . as well as the future . . . are available for study.

Dr. Evans noted ". . . there is no dependable knowledge about how our present medical care system works." To support this point, he cited these questions . . . How do patients enter the system? How do patients become lost from it or lost in it? Where do they really seek care and why? Do the patients really follow physicians' recommendations?"

In furthering his point, Dr. Evans said, "We need information on how we can make our nationally decreasing ratio of physicians more productive, while production of new physicians and other health workers catches up with our rising population." He noted that the York area has not suffered decreasing numbers of physicians, as most other areas have.

"Do our physicians know about the discoveries of modern research . . . or is the problem one of bringing the discoveries to them in a form that can immediately be put to use?" questioned Dr. Evans.

"For example," he said, "the study may disclose that more efficient office management or better use of ancillary personnel will make medical care better, or that complicated new techniques requiring special education will produce the greatest change in medical care."

He summed up the study's approach by saying, "Finally, the unit would function to identify changes in patients and physicians after attending specialized educational programs designed as a result of the knowledge gathered by the unit." If care is made more readily available for the patient, and more efficient for the patient, physician, and hospital, the cost of care should be decreased.

In the first year of operation the unit, headed by Patricia Johnson, a Ph.D. graduate of the University of Southern California with a major in medical education measurement, would establish a planned program and set up initial evaluations which can be carried out by personnel already available within the hospital. As personnel are added, immediate use can be made of present and past information already available in computer and study records.

In its complete form, the unit would be available to serve as a medical care system information and study center. The unit would be staffed by an educator, a physician, a sociologist, systems analyst, psychologist, and other personnel required to establish, carry out, evaluate and consult on studies of medical care and educational programs. These doctorate members will have graduate student assistants from various colleges and universities, who will provide additional staff.

It is anticipated that financial support for the unit on a continuing basis could come from many areas outside of the Maryland Regional Medical Program funds, once the initial studies have begun. This information will then be useful throughout the Nation.

Noted Harvard Surgeon Washington Hospital Speaker

Dwight Harken, M.D., professor of clinical surgery at Harvard, will be the guest speaker at the Washington Hospital Scientific Day Program, October 9, 1968. Doctor Harken will discuss advances in cardiovascular surgery.

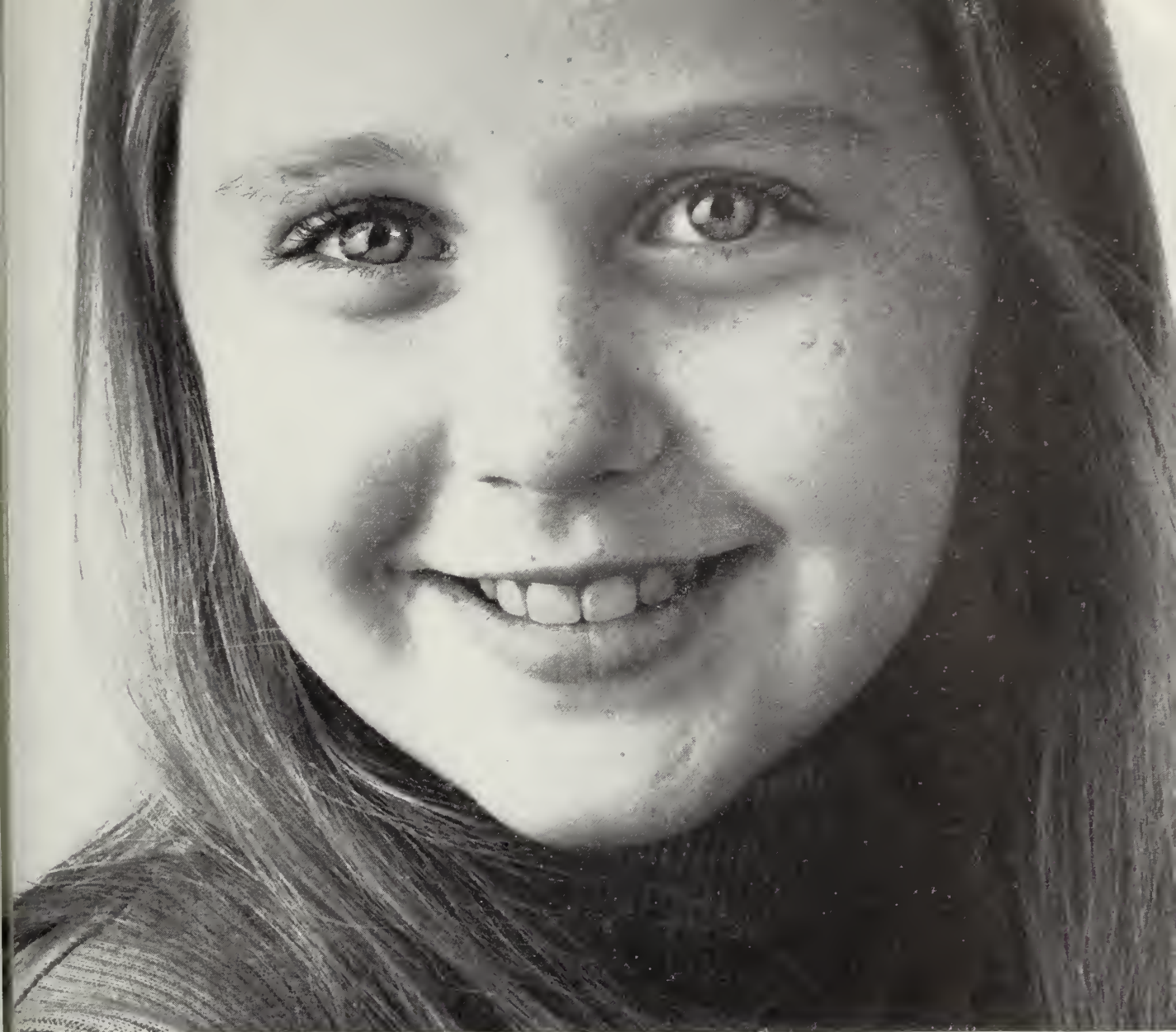


Photo professionally posed.

No injection after all! This penicillin produces high, fast levels—orally.

Pen-Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN·VEE® K**
(potassium phenoxymethyl penicillin) 



Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnosis-

tic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain

(water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

"Pain Break" for an osteoarthritic.

Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil[®] oxyphenbutazone

rate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and angina may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocyto-

penic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

**For complete details,
please see full
Prescribing Information.**

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.



(B) 46-800-A

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TA-5806AR

Help the Needy!



A patient of advancing years may appear to “have everything,” but may well be in need—*medically*. You know the symptoms. She’s tired most of the time. Though there’s nothing wrong with her organically, she suffers from general malaise. Lassitude has become her way of life . . . vague aches and pains her major concern.

Such a patient has entered the “Mediatric Age”—that stage of her life in which she’s an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support she’s apt to need. MEDIATRIC is intended to help keep her more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition

to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period)—Withdrawal

bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

(Contains
15% alcohol†)
‡Some Loss
Unavoidable

Mediatric® tablets · capsules · liquid

Steroid-nutritional compound



AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada

6817

Government Sponsored Insurance Is Advocated

"Voluntary health insurance plans are inadequate" says a Temple physician and chairman of the National Medical Committee for Human Rights (MCHR) "and should be replaced by compulsory government-sponsored insurance programs.

"What I'm calling for is not socialized medicine, but a national insurance, government supported and sponsored with the government subsidizing the penniless," said T. G. G. Wilson, M.D., an assistant professor of research medicine and biochemistry at Temple University School of Medicine.

"In the past the American Medical Association has warned that government involvement in medicine would make slaves out of physicians," Dr. Wilson said.

"That's nonsense. Doctors have found that Medicare did not decrease income, but rather increased it because the charity patient is now paying for improved care.

"A doctor should not have to worry about prescribing treatment for a patient and at the same time worry about what kind of treatment the patient can afford. I believe the doctor-patient relationship must be free of government control but I think there can be pre-paid insurance for all."

Dr. Wilson, who was elected chairman last April of MCHR which fights racial and economic discrimination in health services said "voluntary health insurance isn't adequate. By nature the most needy is the least insured. And voluntary insurance plans make no provisions for prevention of disease or early detection through frequent check-ups. And it's better medicine to prevent disease."

Dr. Wilson noted that voluntary health insurance plans are based on individuals seeking protection on their own. But he added:

"People won't always insure themselves voluntarily. Actually, in order to have lower rates a large group must seek coverage. But most people buy insurance when they approach the greatest risk. Compulsory insurance would cover everyone and result in lower-rate premiums."

Dr. Wilson feels that such compulsory coverage will gain initial ac-



Doctor Groff and portrait.

U. of P. Neurosurgeon Retires

University Receives Painting

A portrait of Robert A. Groff, M.D., wearing his surgical gown and holding his neurologic hood (the headgear he customarily wears during operations) against the background of an operating room, was presented to the University of Pennsylvania during a reception in the Faculty Club which was attended by some 150 of Dr. Groff's friends and associates.

Dr. Groff retired as the Charles Harrison Frazier Professor of Neurologic Surgery and chairman of the neurologic surgery division of the department of surgery at the University of Pennsylvania School of Medicine.

ceptance through gradual broadening of Medicare, which now provides health service for the elderly. The next step would be what he called "pedicare"—providing medical treatment for children.

Dr. Wilson also said voluntary health insurance plans tend to produce what he called "spectacular treatment," such as heart transplants.

"The funds, perhaps \$20,000 spent by the heart patient who has resources either in a voluntary insurance program or other, could go to nourish

He has been a faculty member since 1936, professor and chairman since 1955, and was named the first incumbent of the Frazier chair in 1963. Though relinquishing his administrative duties, Dr. Groff will retain the post of professor.

David Dunn, M.D., chief resident in neurologic surgery at the Hospital of the University of Pennsylvania, presented the portrait to the University. It was accepted on behalf of the University by President Gaylord P. Harnwell. Dr. Groff's portrait was painted by Philadelphia artist Agnes Allen. The portrait is a gift of Dr. Groff's friends, past and present residents.

hundreds of children."

Looking at Medicare in a hard light, he said, people over 65 "are the wrong end to start" in providing such service.

"Of course, the elderly deserve medical care as much as anyone," Wilson said. "But when people say to me 'our resources are limited and we can handle only one-eighth of the population' then I think that group should be the children. Start with the children, who then can face their next 25 years in good shape."

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been re-

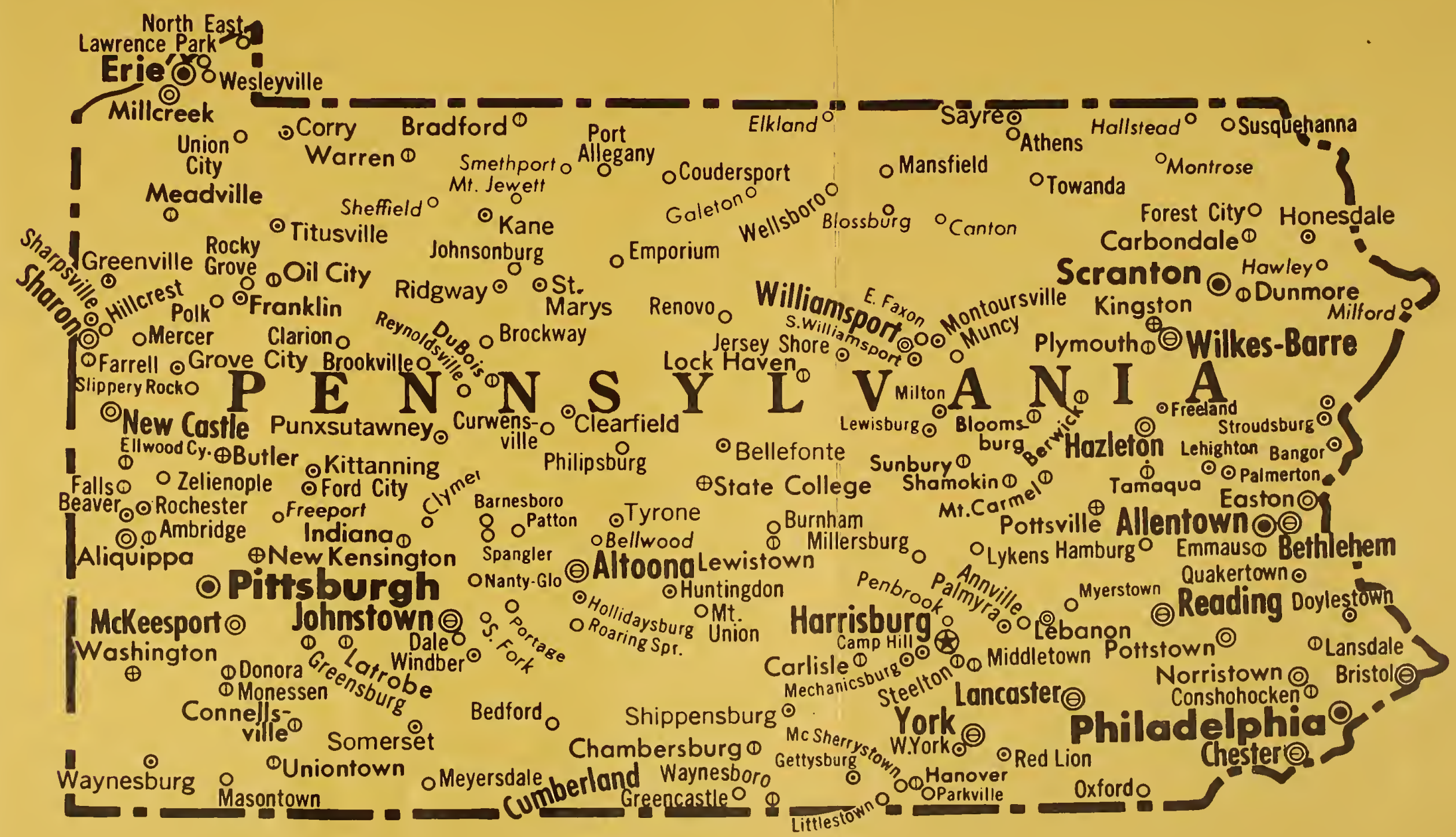
ported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN[®] V
TETRACYCLINE CAPSULES

ACHROMYCIN® WORKS HERE

TETRACYCLINE



ACHROMYCIN[®] WORKS HERE

TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

The cost differential—inconsequential



LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965



You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.



The Network
for Continuing
Medical
Education

NCME TV Offers These Practical Benefits:

- ☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.
- ☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.
- ☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including:
Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.
- ☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.
- ☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

**when aging
brings
anguish**

LEPTINOL®

Improvement of mental alertness and awareness in the management of the senility syndrome requires a comforting environment, a stimulating dietary regimen and concomitant drug therapy.

LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses.

LEPTINOL® is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day.

Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.

Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

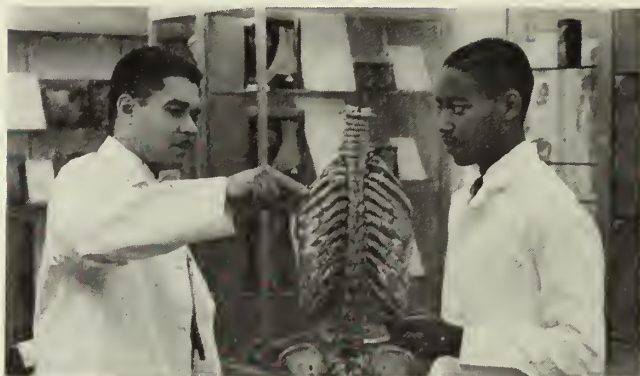
THE VALE CHEMICAL COMPANY INC.



Pharmaceuticals
Since 1922

ALLENTOWN, PENNSYLVANIA 18102

newsfronts



Student Ira Ross participates in medical examination conducted by Raymond L. Hayes, Jr., M.D., in the Gross Anatomy Laboratory at the University of Pittsburgh School of Medicine.

Pitt Medical Career Orientation Program Establishes Black Community Involvement

The University of Pittsburgh's School of Medicine has initiated a Medical Career Orientation Program for black high school students from local communities. Fourteen students selected through community representatives are enrolled in the program for a ten week training experience in research and clinical laboratories in the Schools of the Health Professions and affiliated hospitals. Each student is working with a faculty member to acquire skills in and an appreciation for basic medical technology.

Along with this experience, the students will attend seminars on college preparation for a medical career, paramedical career opportunities and opportunities in medical research. They will participate in medical rounds and open house tours of departments within the medical and dental schools. It is anticipated that through such exposure the students may become aware of the possibilities for careers in the health professions, may be motivated to prepare for such a future, and may make personal contacts with representatives of the faculty of the School of Medicine to assure fulfillment of these goals.

The program is a part of a University-wide commitment and one of the initial attempts on the part of the School of Medicine to define its relationship and responsibility to the local community. One of the possible benefits of the program would be an increase in the number of black students at the University in both the undergraduate and medical schools. It is also the desire of those who have established the program that each student grow to his fullest capacity and level of achievement during his academic career.

Mild Flu Season Expected

A mild 1968-69 flu season has been predicted by the Public Health Service for most of the nation, including the Middle Atlantic states. Possible exception is the Pacific Coast. Little or no Asian (A2) flu is expected and only scattered cases of type B are anticipated. The Health Service is not recommending routine vaccination for healthy adults and children. For high-risk groups, the Health Service says the bivalent vaccine should provide greater protection than the polyvalent type.

A description of the high-risk group, dosage and the dosage route is provided on page 21-22 of the July 29 issue of the JAMA.

Alcoholism: East and West

Pennsylvanians and Russians will meet on a common ground this month to discuss a common problem—alcoholism—the subject of a major international Congress in Washington, D.C.

The event is the 28th International Congress on Alcohol and Alcoholism scheduled for September 15-20. Registration is expected to approach 2,000 with representatives of 20 foreign countries including the Soviet Union, Poland, Yugoslavia, Czechoslovakia, Hungary and Rumania already registered.

Information regarding the program may be obtained by writing: Secretariat, 28th International Congress on Alcohol and Alcoholism, 1130 Seventeenth Street, N.W., Suite 615, Washington, D.C. 20036.

Award Honors Negro Leader

Philadelphia General Hospital is setting \$10,000 as a goal for the Dr. Martin Luther King, Jr. Humanitarian Award, which will be presented annually to rehabilitation groups and students for educational purposes, it was announced today by Dr. Walter J. Lear, acting executive director of PGH.

The Award will be in the form of a scholarship for individuals and as a grant to organizations involved in helping the disadvantaged in the community.

Medical and nursing staff and alumni of PGH educational programs are invited to contribute to the King Memorial Fund. Contributions to the Fund are being sent to Mrs. Priscilla Collins, Medical Records Department, PGH.

Jefferson Campaign Sets Record

An all-time record of \$292,617 was raised in the 1967-68 alumni annual giving campaign at the Jefferson Medical College of Philadelphia. J. Wallace Davis, M.D., chairman of the campaign committee, said this total represents a 33 percent increase over the previous year.

This was the 20th annual giving campaign at Jefferson whose alumni have now given \$2,778,340.

Q. How much does the **anticostive*** hematinic cost?

A. No more than costive hematinics cost!

The anticostive hematinic is

PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate).....	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron).....	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C.....	200 mg
Niacinamide.....	30 mg
Folic Acid.....	0.05 mg
Pantothenic Acid.....	15 mg

Bottles of 60



anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?



LEDERLE LABORATORIES

A Division of American Cyanamid Company
Pearl River, New York 10965

Diarrhea

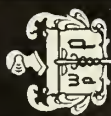
TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



newsfronts

Pennsylvanians in the Lead



Two Geisinger Medical Center interns received awards for excellence in scientific writing from the PMS. James M. Cole, M.D. (right), president, presents the first award to Thomas C. Royer, M.D., of Bellefonte and second prize went to Palmer C. Evans, M.D., of Coaldale. Subjects of the prize-winning papers were: "Blunt Abdominal Trauma," Dr. Royer and "Carcinoma in Situ of the Uterine Cervix," Dr. Evans. The Montour County Medical Society presents these awards annually to stimulate research and investigative writing among the young doctors at the Medical Center.

Writing Awards Presented

Arthur D. Little, Inc., of Cambridge, Mass., is joining a government-sponsored effort to help provide better home care for patients with kidney ailments that twenty years ago were considered fatal.

Under a contract with the Department of Health, Education and Welfare's Public Health Service, the international engineering, research and management consulting organization will evaluate the range of home-care apparatus that function in lieu of the natural kidney. One objective of the 18-month program will be to provide recommendations that ultimately could lead to construction of an "ideal" artificial kidney device.

Philadelphia County Medical Society Conducts 13th Annual Nutrition, Metabolism Confab

The Committee on Nutrition and Metabolism of the Philadelphia County Medical Society is holding its 13th Annual Conference October 23, 1968 in the Auditorium of Temple University Medical Center. The highlight of the Conference is an address by Professor John Yudkin, Queen Elizabeth College, University of London, England, on *The Role of Nutrition in Cardiovascular Disease*.

The afternoon session is devoted to four workshops on nutritional and metabolic aspects of (1) renal disease, (2) diabetes mellitus, (3) preventive cardiovascular disease and (4) malabsorption syndrome. Speakers for the workshops are drawn from the faculties of the local medical schools.

For further information, please write Michael G. Wohl, M.D., Chairman, or Charles Shuman, M.D., Co-chairman, Committee on Nutrition and Metabolism, Philadelphia Medical Society, 2100 Spring Garden St., Philadelphia, Pa. 19130.

To fight TB- find it first!

Make tuberculin testing routine
with every physical examination.



TUBERCULIN_{TINE} TEST

(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



330-8/6135



After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
... soothes colicky pain with paregoric*
... consolidates fluid stools with pectin
... adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.



Parepectolin[®]

Each fluid ounce of creamy white suspension contains:

*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid
ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.



close-up/MD's

Robert Hicks Holmes, M.D., has been named director of medical affairs at Hahnemann Medical College and Hospital, Philadelphia. **Carl C. Fischer, M.D.**, who has served as acting director of medical affairs since July, 1967, becomes associate director. A graduate of Wake Forest College and Tulane Medical School in 1940, Dr. Holmes interned at Brooke General Hospital, Ft. Sam Houston, Texas. He later became a resident in pathology there and also had a residency in pathology at the Armed Forces Institute of Pathology and at Duke University. During World War II, Dr. Holmes served in the European Theater of Operations.

Ivan D. Baronofsky, M.D., has been named professor and chairman of the Department of Surgery at Hahnemann Medical College and Hospital, Philadelphia. Most recently, Dr. Baronofsky has been clinical professor of surgery at the University of Southern California, consultant in thoracic surgery at the U. S. Naval Hospital, San Diego, and research associate Scripps Clinic and Research Foundation. He has staff appointments at several San Diego area hospitals. He is certified by the American Board of Surgery and the Board of Thoracic Surgery.

Frank D. Gray, Jr., M.D., Philadelphia, has been named to the new post of director of the Division of Medicine at Lankenau Hospital, effective this month. Dr. Gray is former director of the Section of Chest Diseases at Yale-New Haven Medical Center and associate professor of medicine at Yale University. The division of medicine which Dr. Gray will head includes the departments of internal medicine, dermatology, and neurology and psychiatry. Chiefs of the department are, respectively, **Malcolm W. Miller, M.D.**, **John W. Lentz, M.D.**, and **Charles Rupp, M.D.**

Arnold S. Relman, M.D., has been named chairman of the department of medicine at the University of Pennsylvania School of Medicine. The appointment, which is effective September 1, 1968, was announced by Dr. Gaylord P. Harnwell, University president. In addition to the chairmanship, Dr. Relman will be the Frank Wistar Thomas Professor of Medicine. He comes to Pennsylvania from Boston University School of Medicine where he is Conrad Wesselhoef Professor of Medicine and vice chairman of the department of medicine.

Leonard S. Girsh, M.D., clinical assistant professor of internal medicine—Allergy, Temple University Medical Center, was guest speaker at the Symposium of Pediatric Allergy presented in Hartford, Connecticut. The Symposium was sponsored by the Saint Francis Hospital Association.

Two members of the faculty of the department of psychiatry, Hahnemann Medical College and Hospital of Philadelphia, have been named to lead major segments of Hahnemann's Community Mental Health Program.

Franklin H. West, M.D., clinical professor of psychiatry, will be chief of the Hahnemann Psychiatry Service at Philadelphia General Hospital and **Robert Nathan, M.D.**, clinical assistant professor of psychiatry, will be chief of the Hahnemann Day Hospital and In-Patient Service.

The Pittsburgh Allergy Society has elected the following officers for 1967-1968: **Richard R. Weigler, M.D.**, president and **William C. Updegraff, M.D.**, secretary-treasurer.

Howard J. Rogers, M.D., a department chairman at the National Institute for Medical Research in London, England, has joined Temple University School of Medicine staff as a visiting professor in microbiology. During his three months at Temple, Dr. Rogers will lecture and conduct laboratory work for graduate students in biochemistry, microbial physiology and metabolism. Dr. Rogers, former editor-in-chief and now an editorial board member of the *Biochemical Journal*, also will work on selected problems in bacterial biochemistry and physiology.

Harold G. Scheie, M.D., Ardmore, was elected president of the Pennsylvania Academy of Ophthalmology and Otolaryngology, a statewide association of eye, ear, nose and throat physicians, at the Academy's annual convention. The gavel was presented to him by **John T. Dickinson, M.D.**, retiring president. Dr. Scheie is the William F. Norris and George E. deSchweinitz professor of ophthalmology and chairman of the department of ophthalmology at the University of Pennsylvania School of Medicine. He is also professor and chairman, department of ophthalmology, Graduate Division of Medicine, University of Pennsylvania.

Jacob Gershon-Cohen, M.D., is the recipient of the 32nd annual Clement Cleveland Award of the American Cancer Society's New York City Division. The yearly citation "for dedicated service to the cause of cancer control," was presented at a reception in New York



DR. GERSHON-COHEN

City's Harvard Club. Dr. Gershon-Cohen was elected recently to the Board of Trustees of the 1,000-bed Philadelphia Albert Einstein Medical Center. He pioneered for many years in the use of mammography and thermography as diagnostic tools for the early detection of breast cancer while he was director of Einstein's Division of Radiology. He now is a member of the center's emeritus consultant staff.

Leonard Bachman, M.D., director of the division of anesthesiology at The Children's Hospital of Philadelphia, has been elected president of the Pennsylvania Society of Anesthesiologists. He succeeds **Peter Safar, M.D.**, professor of anesthesiology at the University of Pittsburgh School of Medicine. Dr. Bachman is professor of anesthesiology at the University of Pennsylvania School of Medicine.

T. F. McNair Scott, M.D., senior physician and former director of research, has been chosen for this year's citation by the League of The Children's Hospital of Philadelphia. Dr. Scott is principal investigator in the hospital's Child Growth Program and professor of pediatrics in the University of Pennsylvania School of Medicine.

Howard Balin, M.D., assistant professor, obstetrics and gynecology, University of Pennsylvania, Graduate Division, School of Medicine, has recently been appointed as Medical Consultant to WCAU-TV (CBS Philadelphia). In this capacity he has helped to design a series of continuing educational programs for the local medical community.

N. Henry Moss, M.D., Merion, president of the Wainwright Tumor Clinic Association, presided at the 38th annual meeting in Philadelphia. Speakers included **Charles A. Waltman, M.D.**, Easton, and **Judith S. Mausner, M.D.**, Philadelphia. Officers elected at the business meeting were **Richard B. Magee, M.D.**, Altoona, president; **Horatio T. Enterline, M.D.**, Philadelphia, president-elect; **William Tyler Douglas, M.D.**, Harrisburg, vice-president; **William H. Frank, M.D.**, Johnstown, secretary, and **George R. Greenwood, M.D.**, Bethlehem, treasurer. Directors elected for a three year term were **George A. Hahn, M.D.**, Philadelphia; **W. C. Corsello, M.D.**, Pittsburgh, and **M. Peter Scibetta, M.D.**, Erie.

Herbert Needleman, M.D., a Temple University psychiatrist who has sought to relieve the suffering of children injured in the Vietnam war, has been named recipient of the Brith Sholom Humanitarian Award. The award from one of the nation's leading Jewish fraternal societies was presented to Dr. Needleman June 23 during the organization's annual convention in Swan Lake, N. Y. Past winners of the Humanitarian Award include former President Franklin D. Roosevelt; his wife, Mrs. Eleanor Roosevelt; Trygvie Lie, former secretary-general of the United Nations; novelist Pearl S. Buck and Sister Elizabeth Kenny.

Wilbur J. Cohen, secretary designate of the U. S. Department of Health, Education and Welfare, has appointed a council to advise him on matters relating to Medicaid (Title XIX) matters. Pennsylvania has one representative on the twenty-one member council—**Thomas W. Georges**,

M.D., of Harrisburg, Secretary of Health and Public Welfare.

John W. Hope, M.D., chief of radiology at The Children's Hospital of Philadelphia spoke in four Colombian cities from June 19 through July 3. His South American tour included the Hospital of the Universitario del Valle in Cali, and the pediatric and roentgenologic societies in Medellin, Bogota and Barranquilla. Dr. Hope is professor of radiology at the University of Pennsylvania School of Medicine.

Glen R. Leymaster, M.D., president and dean of The Woman's Medical College of Pennsylvania, presented two of the College's teachers, **Elsie Reid Carrington, M.D.** and **William K. Riker, M.D.**, with the Christian R. and Mary F. Lindback awards for distinguished teaching. The presentations were made during the 116th Commencement exercises of the College.

The Pennsylvania Society of Internal Medicine at its Annual Meeting at Seven Springs Mountain Resort elected the following officers for the 1968-1969 term of office: **Robert S. Pressman, M.D.**, Philadelphia, President; **James A. Collins, M.D.**, Danville, President-elect; **William J. Kelly, M.D.**, Pittsburgh, Secretary; **Raymond C. Grandon, M.D.**, Harrisburg, Treasurer.

C. Everett Koop, M.D., Philadelphia, surgeon-in-chief of The Children's Hospital of Philadelphia, received an honorary degree of Doctor of Medicine from the University of Liverpool (England) on July 13. On July 17, also in Liverpool, Dr. Koop addressed a meeting of the British Association of Pediatric Surgeons. Dr. Koop, the only American in the Association's executive council, is professor of pediatric surgery at the University of Pennsylvania School of Medicine and editor of the *Journal of Pediatric Surgery*.

Charles N. Chasler, M.D., associate professor of radiology at the University of Pittsburgh Medical Center, completed a three month tour as a volunteer physician in Vietnam recently. This was his second tour of duty in Vietnam. While there he was able to volunteer his radiological services to several army installations which had a temporary shortage of radiologists. He also worked with Catholic Relief Services caring for approximately 6,000 refugees in the Cholon area.

With Lieutenant Commander **James Vorosmarti, Jr.**, Medical Corps, U.S. Navy, of Palmerton assigned as medical officer of the project, the sea arm of our armed forces has selected five Pennsylvanians among 54 men to serve as Aquanauts in the forthcoming SEALAB III experiment.



DR. VOROSMARTI

Doctor **Vorosmarti**, the son of Mr. and Mrs. James Vorosmarti, Sr., of 244 Lehigh Avenue, Palmerton, Pa., received his Bachelor of Arts from Lafayette College and his Doctor of Medicine from Jefferson Medical College. He interned at the Naval Hospital in Portsmouth, Va., from 1961 to 1962.

David L. Miller, M.D., New Bethlehem is currently serving a two month tour of service with the Bangkok Christian Hospital, Bangkok, Thailand. **R. B. Erickson, M.D.**, will serve in Dr. Miller's local office.

Marvin T. Hunter, M.D., Philadelphia, was presented with the Alan Edelson Prize which recognizes a senior student who demonstrated outstanding leadership and service to the class and the college. **Patricia Lyons**, Buffalo, New York, received the Langford Memorial Prize awarded to the student demonstrating outstanding humanity in medicine. **Neil Schlackman, M.D.**, Philadelphia, was given the C.S. Raue Pediatric Division Award for the member of the graduating class with the highest average in pediatrics. **Jerald Fingerut, M.D.**, Philadelphia, received the Gerald Pearson Award in Child Psychiatry for outstanding performance. **Hazel Weinberg, M.D.**, New York City, who was a teacher in the New York School System for eight years before coming to medical school, received the psychiatry prize for outstanding performance.

Randolph C. Blodgett, Jr., M.D., Danville, has been elected vice president of the American Society for Clinical Rheumatology. The Society consists of selected physicians from around the United States who practice rheumatology and will assist in the exchange of information on therapy and clinical research to promote a better level of care for patients with arthritis.

An anorectic will help her lose weight—
but can she keep it off?
You need more than a pill
(even ours) to do that!



That's why Abbott offers you a pill plus a program.

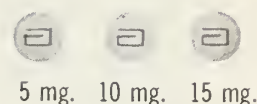


The Product

*For smooth appetite
control plus mood
elevation*

DESODYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form



*For patients who can't
take plain amphetamine*

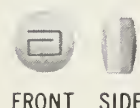
DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL® 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

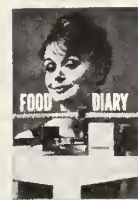
Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



*Please see Brief Summary
on next page.*

Ask Your Abbott Man For Free Supplies

801444

Brief Summary

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society
in recent months:

ALLEGHENY COUNTY:

- HARVEY W. AUSTIN, M.D., 722 McCurdy Place, Pittsburgh 15202.
CHARLES E. COPELAND, M.D., Mercy Hospital, Pittsburgh 15219.
GARY A. LEVINSON, M.D., 5921 Douglas Street, Pittsburgh 15217.
HAZEL F. SAMILOWITZ, M.D., 3437 Fifth Avenue, Pittsburgh 15213.
LEONARD A. STEPT, M.D., 5922 Howe Street, Pittsburgh 15232.
JOSEPH R. WAYLONIS, M.D., 2000 West Street, Munhall 15120.
RONALD L. ZIMMERMAN, M.D., 2811 Rollins Drive, Allison Park 15101.
HERNANDO SALAZAR, M.D., Magee-Womens Hospital, Pittsburgh 15213.
STUART D. HIRSCH, M.D., 3811 O'Hara Street, Pittsburgh 15213.
JOHN B. JOSIMOVICH, M.D., Magee-Womens Hospital, Pittsburgh 15213.
MARY D. LEHMAN, M.D., Armed Forces Inst. of Pathology, Washington, D.C. 20305.
HUBERT S. LEVENSON, M.D., 750 Herkness Street, Philadelphia 19124.
JULIUS MAZER, M.D., 5501 Hobart Street, Pittsburgh 15217.
SAMUEL C. MINES, M.D., 242 Dan Drive, Pittsburgh 15216.
DAVID J. SMITH, M.D., 525 William Penn Place, Pittsburgh 15230.
MARTIN TAXAY, M.D., 715 North Highland Avenue, Pittsburgh 15206.
RUBEN A. TELAN, M.D., Children's Hospital, Pittsburgh 15213.

BRADFORD COUNTY:

- LEWIS N. THEOHAROUS, M.D., 193 South Keystone Avenue, Sayre 18840.
JAMES S. TY, M.D., Guthrie Clinic Ltd., Sayre, Pa. 18840.
JAIME P. SALINDONG, M.D., Robert Packer Hospital, Sayre 18840.
JOHN A. KELLY, M.D., 116 South Wilbur Avenue, Sayre 18840.
KAZUTOSHI KIKKAWA, M.D., Guthrie Clinic, Wilbur Avenue, Sayre 18840.
RICHARD E. SHELLING, M.D., Robert Packer Hospital, Sayre 18840.
SANDRA S. FERRY, M.D., Robert Packer Hospital, Sayre 18840.

CLINTON COUNTY:

- FREDERICK F. YOUNG, M.D., Crestmont, R.D., Lock Haven 17745.
GURBACHAN S. JANDA, M.D., 322 Erie Avenue, Renovo 17764.

ERIE COUNTY:

ROBERT J. MARSH, M.D., 225 West 25th Street, Erie 16502.

FAYETTE COUNTY:

YING P. LEE, M.D., 30 Delaware Avenue, Uniontown 15401.

LUZERNE COUNTY:

DOMINICK A. CRUCIANI, JR., M.D., Kehoe Building, Suite 300, Pittston 19640.

LYCOMING COUNTY:

WILLIS W. WILLARD, III, M.D., 33 West Southern Avenue, South Williamsport 17701.

McKEAN COUNTY:

ANITA J. HERBERT, M.D., 406 Hooker-Fulton Building, Bradford 16701.

MONTGOMERY COUNTY:

IVES C. THILLET, M.D., 17 Rosedale Drive, Pottstown 19464.

ARTHUR MARTELLA, JR., M.D., 233 South Trooper Road, Norristown 19401.

LONNIE E. FULLER, M.D., State Hospital, Norristown 19401.

MONTOUR COUNTY:

WILLIAM J. KIMBER, M.D., Geisinger Medical Center, Danville 17821.

NORTHAMPTON COUNTY :

GLADYS D. MORALES-BALABKINS, M.D., 65 East Elizabeth Avenue, Bethlehem 18015.

THEODORE J. KOWALYSHYN, M.D., St. Luke's Hospital, Bethlehem 18015.

WILLIAM M. STRUNK, M.D., St. Luke's Hospital, Bethlehem 18015.

JOHN J. RYAN, M.D., St. Luke's Hospital, Bethlehem 18015.

CARRIE K. SCHOPF, M.D., St. Luke's Hospital, Bethlehem 18015.

NORTHUMBERLAND COUNTY:

LEON E. LESHOCK, M.D., Box 65, R. D. 1, Paxinos 17860.

UNION COUNTY:

JOSEF KLESAL, M.D., Laurelton State School, Laurelton 17835.

VENANGO COUNTY:

RONALD L. REDFIELD, M.D., 206 Reed Street, Oil City 16301.

KAMAL H. AOUN, M.D., 1228 Elk Street, Franklin 16323.

WAYNE-PIKE COUNTY:

ALFREDO R. CANDAL, M.D., 507 High Street, Honesdale 18431.

EVA M. C. FODOR CANDAL, M.D., 250 Ridge Street, Honesdale 18431.

WESTMORELAND COUNTY:

CONCHITA Q. SANDOVAL, M.D., 607 Lewis Avenue, Jeanette 15644.

SEPTEMBER, 1968



painful night leg cramps...

respond to specific therapy with QUINAMM™

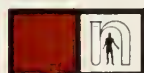
(Quinine sulfate, 260 mg., Aminophylline, 195 mg.)

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



"With this diet you can eat anything you like, here's a list of the things you like!"

OBETROL[®] for weight control

Each OBETROL-10 tablet contains: Methamphetamine Saccharate 2.5 mg.; Methamphetamine Hydrochloride 2.5 mg.; Amphetamine Sulfate 2.5 mg.; Dextro-amphetamine Sulfate 2.5 mg.; (OBETROL-20 tablets contain twice this potency) Pat. #2748052.

This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hypersensitive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

Dosage and Administration: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100, 500, and 1000.

REQUEST SAMPLES AND LITERATURE

OBETROL PHARMACEUTICALS • BROOKLYN, N.Y. 11207

DR. _____

ADDRESS _____

CITY _____ STATE _____

SIGNATURE _____

OBETROL PHARMACEUTICALS
Div. of Rexar Pharmacal Corp., Brooklyn, N.Y. 11207

PENNSYLVANIA MEDICINE

PMS Challenges Chiropractic Coverage

The Honorable Raymond P. Shafer, Governor
State of Pennsylvania
225 Main Capitol Building
Harrisburg, Pennsylvania

Dear Governor Shafer:

I would like to take this opportunity, on behalf of the Pennsylvania Medical Society, to register strong opposition to H-1474, Printer's No. 3693, which was approved finally by the House of Representatives on Monday, July 15, and sent to you for your signature.

The main reasons for Medicine's opposition to this measure are the inclusion of chiropractic services, and, secondly, since no new legislation in this area is thought to be necessary until 1969, we would like to have further opportunity to plan a new program with the Secretary of Public Welfare, Thomas W. Georges, M.D., in keeping with those plans that Dr. Georges and we have discussed and then expressed to you last year when we met.

The inclusion of chiropractic services seems to us to be scientifically unthinkable. The chiropractors themselves have conceded to not practicing any form of medicine, with which we certainly concur, and, consequently, their practice does not belong in a medical care program.

I am attaching to this letter copies of advertisements which we have collected from the state's newspapers which frankly frighten us, as they are misleading, unjustified and unhealthy in that they tend to encourage people with possible serious conditions to rely on the services of chiropractic, which, by law and training, they are not capable of undertaking.

In a letter that I sent earlier to Senator Albert Pechan, Chairman of the Senate's Committee on Public Health and Welfare, I tried to point out the medical reasons why we were so opposed to chiropractic. I am taking the liberty of quoting some of these paragraphs here so that you can see that we are not opposed to chiropractic for, as they say, "financial reasons," but only because they adhere to a dogma and completely refuse to recognize scientific bases.

"As a dental surgeon, it will be obvious to you why physicians are so vigorously opposed to chiropractic. There seems to be no scientific basis for chiropractic's existence. It is impossible to define chiropractic accurately, because it has no fixed universal meaning and even varies in definition from state to state. It can truthfully be stated that chiropractic is the largest unqualified group in the country practicing medicine, either legally or illegally.

"The present century has been called the age of the scientific revolution. The advantage to contemporary man is enormous—not only because of the everyday practical application of these discoveries, but also because he has thrown off the yoke of superstition. In this era of superhuman achievement, each intelligent individual owes it to himself to apply scientific criteria before accepting any new theory of man's phenomena. Nothing can be accepted as fact; no relationship between two facts can be accepted

as established unless proved beyond all doubt. The chiropractors make many 'scientific' claims, but have yet to submit these claims to at least a minimum of scientific investigation. For instance, chiropractors claim that subluxations or partial displacements of the vertebrae cause a perturbation of the distribution of nervous impulses to tissues and cells. Neurophysiologists have developed methods of recording the passage of impulses in nerves. Exceptionally sensitive apparatus is available to anyone wishing to use it. No scientific study has yet been published on this subject by a chiropractor. No chiropractor has ever defined, either quantitatively or qualitatively, what chiropractic means by perturbation of nervous impulses. Is it their number, their amplitude their frequency, the speed of their propagation, or their wave patterns which are affected? All of these qualities can be identified, recorded and studied. It is no longer permissible to accept empirical statements. Proof should have preceded practical application. With the first point untenable, the rest crumbles. In pure scientific logic, the argument should not need to go further than this.

"It is indeed astonishing that there has been such a lack of effort or of concern for scientific truth, especially if one considers the effort which has gone into selling their theory to the general public—when the world to be convinced was the scientific world. Let the theory gain acceptance in the world of scholars, and all of the troubles of the chiropractor will vanish.

"There should be no reimbursement by insurance companies to practitioners of the healing arts enjoying a double standard of education and licensing. The educational requirements of physicians, dentists, nurses and other scientific practitioners are so different from those that apply to qualifications of chiropractic licensure that it doesn't bear a comparison. To this point, the United States Supreme Court, in a landmark opinion, has upheld the ruling of the U.S. District Court in New Orleans that the State of Louisiana can properly refuse to license chiropractors *unless they meet the same educational standards* required of medical practitioners. The ruling in 'England vs. Louisiana State Board of Medical Examiners' had been handed down by a three-judge panel in New Orleans Federal Supreme Court. In its ruling of June 20, the U.S. Supreme Court held, in effect, that the equal protection clause of the 14th Amendment of the U.S. Constitution does not bar Louisiana from requiring chiropractors to have medical school degrees. In its unanimous November decision, the three-judge Federal District Court had rejected the chiropractors' argument that their constitutional rights were being violated. The three judges found that 'there has been no showing here that the state had done more than is necessary to protect the health of its citizens.' The court opinion also said, 'If the education obtained in chiropractic schools does not meet the standards of—the United States Office of Education, it may well be that the Legislature of Louisiana felt that in the public interest a diploma from an approved

capitol report

medical school should be required of a chiropractor before he is allowed to treat all the human ailments chiropractors contend can be cured by manipulation of the spine.'

"In amazing testimony presented by the President of the National College of Chiropractic before the court, he testified that he did not teach artificial immunization; when asked, 'What specific centers would you adjust for tetanus?' he replied, 'To normalize the vasomotor extension, of course, you would adjust in the lower lumbar spine.'—Need I say more?"

Because of Dr. Pechan's background, he was one of the few in the Senate who thoroughly understood what we were arguing for and against. Unfortunately we were not

able to convey to others, and the arguments against us "for financial reasons" seem to be the ones that were heard.

We are informed by Dr. Georges that it may be impossible for you to veto this bill for legal reasons in keeping with an opinion which he has from the Attorney General. However, we ask you to give serious thought to vetoing this bill and giving us an opportunity, with Dr. Georges, between now and the beginning of the year, to work on a program of which Pennsylvania can be proud.

Sincerely,

JOHN H. HARRIS, Sr., M.D.
President, PMS

July 30, 1968

Dr. John H. Harris, Sr.
President, Pennsylvania Medical Society
Taylor Bypass and Erford Road
Lemoyne, Pennsylvania 17043

Dear Doctor Harris:

In Governor Shafer's absence from the office, I would like to take this opportunity to acknowledge your letter of July 17, concerning House Bill 1474.

I am sure it was never this administration's desire to become involved in a dispute within the medical profession. As you know, our Pennsycare legislation was introduced without the inclusion of chiropractic services. The bill was later amended to have them included. While there was some effort mounted to change the bill back to its original form, there was no legislative support to do so and the bill was passed and sent to the Governor in its present form.

Under the circumstances when discussing this matter with the Governor it was his expressed intention to sign the bill in its present form, and I expect this will be accomplished within the next few days since he must act prior to August 4th.

Please be assured that the information provided in your letter was reviewed prior to reaching the present decision, but I think you can understand the Governor's reticence to publicly disapprove such a vital program as Pennsycare despite some imperfections in the final piece of legislation.

I am sure if the Governor were here he would personally wish to thank you for taking the time to correspond with him on this matter.

Sincerely,

THEODORE R. ROBB
Assistant Secretary for Legislation

House Bill No. 1474, Pennsycare legislation, is now Act 273 and was signed by the Governor on July 31, 1968. The Department of Welfare is already engaged in considering regulations which may have an impact on finding out the kinds of chiropractic practices and methods of treatment which will be of help.

YOU MUST REGISTER BY SEPTEMBER 16!

IF - - - - you have moved.

IF - - - - you have not voted within the last 2 years.

IF - - - - you are returned from military service and have not registered since discharge from the service.

IF - - - - you are a married woman and have not registered since your marriage.

IMPORTANT: If you are a **naturalized citizen**, you must present naturalization papers; or, if you have naturalized through a parent, wife or husband, you

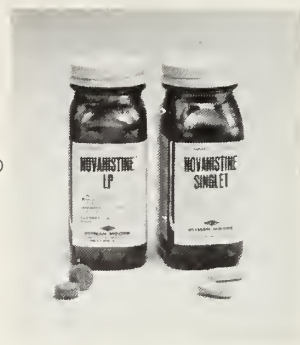
must have the pertinent data issued by the court before which they were admitted to citizenship.

WHEN AND WHERE: Any weekday until Monday, September 16th at the courthouse in your own county or at any city, borough, township or other place designated by your own county court. **Check your daily newspapers for such times and places field registrars will be on duty.** It is not necessary to register in your own **immediate** neighborhood so long as it is in your own county.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accom-

panied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



"Nothing else I've tried seems to work, so I decided to give you a crack at it."



Dear Sir:

As a long-time director of Pennsylvania Blue Shield and as Chairman of the Fee Schedule Committee of that Corporation, I feel it is important to answer the Open Letter relating to various "service benefit" problems which Ralph J. Miller, M.D. wrote to Blue Shield on February 13, 1968 and which was published in your August issue.

Because Dr. Miller is apparently referring to specific cases as the cause of his unhappiness, but manages to make his letter confusing by failing to identify those cases, I decided to obtain additional information concerning this whole situation from the Blue Shield headquarters in Camp Hill. This reply to Dr. Miller's letter is based on the information thus obtained.

Service benefit cases must be handled in accordance with the Blue Shield Regulatory Act of 1939, P.L. 1125, the Blue Shield Subscription Agreements with its Subscribers, the Participating Doctor's Agreement with Blue Shield, and the Blue Shield By-Laws.

Section 9(d) of the Blue Shield Regulatory Act of 1939, P.L. 1125, as amended, contains these provisions:

"(d) Every person of low income and every person of over-income * * * shall be entitled, * * * to the services of any doctor of medicine, doctor of osteopathy or doctor of dental surgery registered with the Corporation * * * Provided further, however, that persons of over-income shall be liable to doctors of medicine, doctors of osteopathy or doctors of dental surgery registered with the corporation rendering services to such persons of over-income, for the full amount of the usual fees and charges for such services * * *."

Thus the Blue Shield Regulatory Act indicates that under-income subscribers are entitled to the services of Participating Doctors without the payment of any fee to such Doctors over and above the Blue Shield fee, and that such Doctors will accept the Blue Shield fee as their sole remuneration for the performance of such services. This concept is also reflected in the Blue Shield Subscription Agreements which provide that Participating Doctors who perform services for subscribers who are under-income shall make no additional charge to subscribers for such services.

This basic concept was approved in an Opinion of the Court of Common Pleas of Delaware County (1966) in a recent case involving Blue Shield as follows:

"These statutory provisions outline the essential and basic features of the Blue Shield Plan for prepaid medical service which, as has already been pointed out, are that medical services will be provided to low income subscribers by participating doctors who have obligated themselves to accept the Blue Shield fee as their sole remuneration. Furthermore, the legislature clearly intended that the Blue Shield Regulatory Act should be liberally construed in order to further the Blue Shield Plan."

This Opinion was affirmed, per curiam, by the Supreme

Court of Pennsylvania, 425 Pa. 630 (1966).

The Participating Doctor's Agreement with Blue Shield provides:

"I am a doctor of medicine licensed to practice in the State of Pennsylvania, and I agree to provide medical services in accordance with 'The Medical Service Plan of the Medical Service Association of Pennsylvania'."

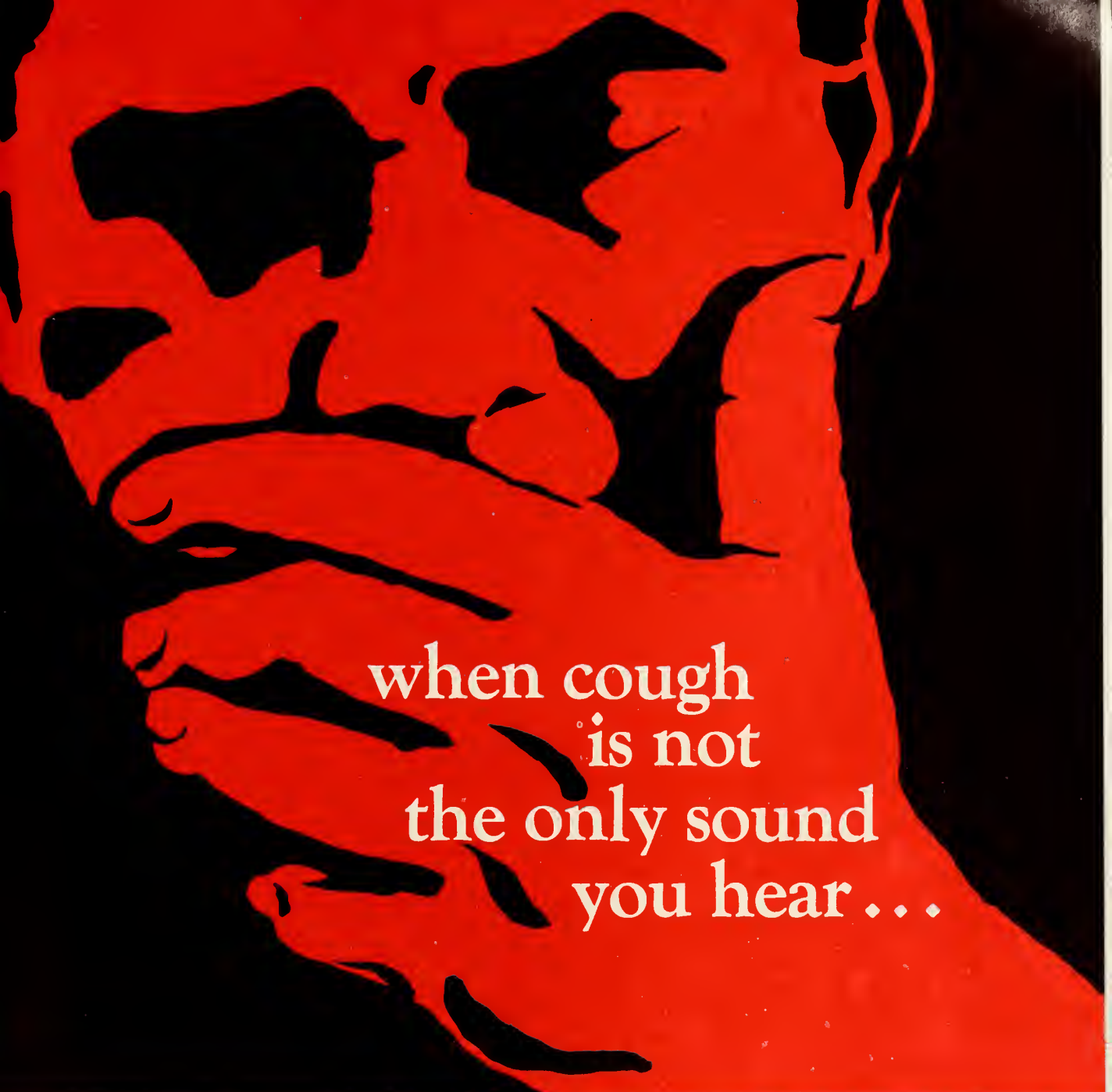
The Blue Shield By-laws, as amended, contain the following provisions relative to Participating Doctors who refuse to recognize the service benefit concept under the Blue Shield Plan: (Article X, Section 6)

"Section 6. Violations of Participating Doctors' Agreements. The Board of Review procedures set forth in Section 5 of this Article X shall not be applicable in determining whether a participating doctor of Blue Shield has violated his Participating Doctor Agreement by refusing to render service benefits to under-income subscribers in accordance with the Blue Shield Plan and in determining whether, if guilty of such violation, the doctor involved should be suspended or dropped as a participating doctor (subject to the approval of the Pennsylvania Department of Health). The aforesaid determination shall be made by those members of the Executive Committee of the Corporation who are doctors of medicine, doctors of osteopathy or doctors of dental surgery, and such determination may be made only after reasonable written notice and opportunity to be heard has been afforded to the participating doctor involved."

At a meeting held December 13, 1967, the Executive Committee of Blue Shield took occasion to review the various problems which arise when Participating Doctors of Blue Shield charge an under-income subscriber a fee which is in excess of that provided in the applicable Blue Shield Fee Schedule. After careful consideration, it concluded that these cases should be handled as follows:

1. If a participating doctor merely submits a bill to an under-income subscriber for a payment over and above the amount of the Blue Shield fee, Blue Shield shall live up to the letter of the law and its By-Laws and inform the doctor that he is violating his Participating Doctor's Agreement with Blue Shield and is subject to being suspended or dropped as a participating doctor, and Blue Shield shall also advise the subscriber that the doctor is not entitled to any fee over and above the Blue Shield fee and that the subscriber should not pay this fee.

2. If a participating doctor actually obtains from an under-income subscriber a payment over and above the amount of the Blue Shield fee, Blue Shield shall reimburse the subscriber for the amount of such overpayment to the doctor. The doctor shall then be requested to return to Blue Shield the excess payment, being advised that if he fails to do so he may be suspended or dropped as a participating doctor. If the doctor fails to return the excess payment, Blue Shield shall deduct the amount of



when cough
is not
the only sound
you hear...

OMNI-TUSS® b.i.d.

... **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.

Children (6-12 years): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

new evidence for TAO[®] (triacetyl- oleandomycin)



a
macrolide
antibiotic for the
frequently seen
respiratory infection
in the office
and
for a problem pathogen*
in the hospital.

*Staphylococcus aureus

study I¹ Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the
organisms were
susceptible
to oleandomycin*

98.0%
of the
patients
responded
favorably
to TAO®(triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II² Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81. (8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

**TAO®(triacetyl-
oleandomycin)**

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS AND PRECAUTIONS: Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.



**J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N. Y. 10017**

In the complex picture
of moderate to severe anxiety...



there is a **new** reason
for prescribing **Mellaril**
(Thioridazine HCl)

**effectiveness in
mixed anxiety-depression**

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System—*

Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System—*Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System—*

Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema.

*Skin—*Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System—*

Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other—*A single case described as parotid swelling.

Mellaril[®]
(Thioridazine HCl)
25 mg. t.i.d.

**for moderate to severe anxiety
and mixed anxiety-depression**



SANDOZ PHARMACEUTICALS, HANOVER, N. J.

68-16



choose an experienced candidate—
millions of doses prescribed



The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals[®], containing 50 mg. of diphenhydramine hydrochloride.

Benadryl[®]
(diphenhydramine hydrochloride)

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

When it's more than a bad cold



**your patient can feel better
while she's getting better**

Achrocidin[®]

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN[®] Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and

may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



349-B

excess payment involved from any amount which may thereafter become payable to the doctor by Blue Shield for services performed for other subscribers.

3. If a participating doctor institutes legal proceedings against an under-income subscriber to force him to pay a fee over and above the Blue Shield fee, Blue Shield shall assist the subscriber in defending such proceedings on the theory that the Participating Doctor's Agreement with Blue Shield bars recovery of such fee from the subscriber. Blue Shield shall also advise the doctor that, unless he drops his claim for such additional payment, he may be suspended or dropped as a participating doctor of Blue Shield.

To return to Dr. Miller's letter and the December 1967 meeting of the Blue Shield Executive Committee which considered the steps to be taken when a Participating Doctor charges an under-income subscriber a fee in excess of the Blue Shield fee, it should be pointed out that nine actual cases, involving eight different doctors, were considered at this meeting. Two of these cases involved patients of Dr. Miller. Blue Shield Management reported to the Executive Committee that a total of \$597.50 had been paid to the subscribers in five of the nine cases involved to reimburse them for the excess charges collected from them by the Participating Doctors. In one other case, it was determined, on the basis of an affidavit from a subscriber, that the subscriber was over-income. The remaining three cases had not yet been resolved at the time of the December 1967 meeting of the Executive Committee.

In the two cases involving patients of Dr. Miller, he appeared to be unwilling to accept affidavits from the subscribers as to the amount of their income and he was apparently considering legal action to collect the additional fees which he claimed. Management of Blue Shield wrote to Dr. Miller in January of 1968 and, when he did not reply, again on April 4, 1968. Dr. Miller then replied to Blue Shield under date of April 12, 1968, stating that he was at a loss to know just what to say to Blue Shield under the circumstances and enclosing two newspaper clippings which suggested that one of the patients involved was enjoying a life of some affluence. This latter subscriber apparently had submitted a sworn affidavit that his income for the year preceding the services received was less than \$2,500 and offered to show his Federal Income Tax Report in support of that fact. It is understood that Dr. Miller was unwilling to consider this Federal Income Tax Report.

As to Dr. Miller's comments concerning the Blue Shield Fee Schedule, that has been the subject of long continued study by the Fee Schedule Committee appointed by the Board of Directors of Blue Shield, and a request for increases in certain fees, in order to correct inequities in the Fee Schedule, was one of the matters considered at a public hearing before Pennsylvania Insurance Commissioner Francis R. Smith in 1960. The requested increases in certain fees were rejected in the adjudication handed down in connection with that hearing. Subsequently, certain requested additions and increases in the Blue Shield fees were allowed by Pennsylvania Insurance Commissioner Audrey R. Kelly.

Additional filings, which Blue Shield contemplated making with the Insurance Department requesting further increases in the Blue Shield fees based on hearings held by the Fee Schedule Committee, have not actually been

submitted because of the issuance of a Relative Value Fee Schedule by the Pennsylvania Medical Society and because of the later development of the "usual, customary and reasonable fee" concept by joint action of representatives of the Pennsylvania Medical Society and Blue Shield. This later concept of payment of fees by Blue Shield has been used in selected areas of Pennsylvania on a trial basis to the complete satisfaction of Blue Shield and the Participating Doctors involved. It is the next, and hopefully, the ultimate solution to the vexing problem of payments to doctors, perhaps soon to be put into practice generally. Interestingly enough, the proposal originated with labor unions and large industrial purchasers of Blue Shield protection.

Dr. Miller's letter affords Blue Shield the doubtfully pleasant opportunity of reminding the 17,413 Participating Doctors again of the Blue Shield procedures in handling these service benefit cases. The fact that out of more than 2 million claims received annually, Blue Shield has only approximately 300 potential cases involving disputes over service benefits, attests the practicality of the method. This public discussion of the Blue Shield method stimulated by Dr. Miller's letter, should be assurance to the 17,413 Participating Doctors and the 5,270,407 Blue Shield Subscribers, of the determination of the Board of Directors and the Management of Blue Shield to protect the interests of all who subscribe to and participate in the largest Blue Shield Plan in the United States.

Lewis T. Buckman, M.D.
Chairman, Fee Schedule Committee
Pennsylvania Blue Shield

Dear Sir:

In the Correspondents' Section, Page 34, of the June issue of the Journal there is a letter from L. J. Hampton, M.D. in which the term "allopath" was used to designate physicians holding an M.D. degree.

This is an archaic term which lost its significance many years ago. Finally, after much effort, the term was eliminated from the language of the Medical Practice Act in Pennsylvania in 1963.

Dorland's medical dictionary gives the meaning of allopath as "An incorrect designation for a regular practitioner," also, allopathy "is an erroneous designation for the regular system of medicine and surgery. The term really means the curing of diseased action by inducing a different kind of action in the body."

John H. Harris, Sr., M.D.
Harrisburg

Dear Sir:

P. S. Article: *The Autopsy* published in the June 1968 issue of PENNSYLVANIA MEDICINE:

The author is in favor of an autopsy rate approximating 100 per cent, or as close to that figure as is possible.

Joseph T. Freeman, M.D.
Philadelphia



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

Announcing the blood chemistries anyone in your office can do. Those using Diagnostest* reagents and instruments. We train your nurse or medical assistant to use this simple, accurate system. For measuring hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. You get results in minutes. And the system includes everything you need. Write today for full information.

* Trademark of The Dow Chemical Company





The Increasing Cost Of Medical Care

News items dealing with the increased cost of medical care are constantly seen in the daily press and heard on radio and television programs. In some instances it is alleged that this increased cost is largely due to increased physicians' fees. Each month the Labor Department reports on the cost of living and invariably it has been an increasing of $\frac{1}{2}$ to 1 percent, and cited among the major price gains is usually medical care. The present administration has charged that the increases in physician and hospital charges is the single most inflationary aspect of the U. S. economy.

The increase in medical care is due mainly to three factors: hospital costs, cost of drugs and appliances, and physicians' fees. Many people believe that the physician has considerable control over hospital costs, and consequently physicians are blamed when costs go up. The major factor in increased hospital costs is labor which takes from 60 to 70 cents of every dollar paid by the patient. The wages paid to unskilled or semi-skilled labor in the hospitals are constantly increasing due to a tight labor market, inflation, and the increase in minimum wages. The salaries paid to skilled help in the hospitals such as nurses, medical and laboratory technicians, etc. are likewise constantly increasing. Physicians on the medical staffs of hospitals have no control whatsoever over these costs. However, the individual physician does have control over unnecessary admissions for short term, limited acute illnesses which could be cared for in the home and for the over-utilization of hospital clinical facilities. Undoubtedly, there has been a marked increase in pressure exerted on the physician by families for admission to the hospitals of elderly patients with minor illnesses who are now under Medicare. To oppose hospitalization of such cases results in arousing the ire of the patient's family, but it must be done if we are going to help in controlling hospital costs.

Physicians' fees are the direct responsibility of the profession and unjustified increases in fees should be controlled. The physicians of Pennsylvania have an adequate review mechanism for investigating exorbitant charges through the District Councilor Review Committees. Specific cases of over-charging can be referred to these review committees by Blue Shield, Medicare, commercial insurance companies, and by the patient.

However, it is questionable whether any large percentage of physicians have increased their fees as the result of Medicare. Pennsylvania Blue

Shield reports that from May 1, 1967 until April 1, 1968 letters have been received from 2,216 participating physicians informing Blue Shield of increases in fees for certain services or in establishing fees for certain new services. The division of the total figure into these two categories is not available at the present time. The total number of participating physicians in the State is 16,944. It is true that patients over sixty-five under Medicare who have previously been treated free or at reduced fees by physicians are now being charged the usual and customary fee. This is quite justified since we as physicians are paying taxes to support this program.

Beginning in April, the premium rate of Part B Medicare was increased from \$3 to \$4 per month for the insured with an equal amount being contributed by the Federal Government. Of this increase, the Dept. of Health, Education and Welfare has estimated that 27 cents is due to increased physician fees. The increase from \$3 to \$4 per month is a $33\frac{1}{3}$ percent increase. Of the $33\frac{1}{3}$ percent increase, 27 cents or 90 percent of the increase is alleged to be due to increased physicians' fees. This increase is for two years since the original premium was established in January 1966 and is not out of line in comparison with increases in wages and salaries as obtained by various labor organizations in new contracts for their members.

The soaring cost in health care has resulted in four different Senate Committees investigating various phases of health care. Senator Abraham A. Ribicoff's Sub-committee on Executive Reorganization is investigating costs of medical care; the Judiciary Sub-committee on Anti-trust and Monopoly, headed by Senator Philip A. Hart, has conducted a series of hearings on doctor relationships with various health industries; Chairman Lester Hill's Labor and Public Welfare Committee is expected to look into the overall hospital dilemma, and last but not least, the Finance Committee headed by Senator Russell B. Long, which oversees the operations of the Medicare and Medicaid programs is constantly reviewing the cost of the programs.

As a result of these various investigations, we hear rumors of various plans for controlling hospital costs and physicians' fees. One rumor regarding control of physicians' fees is that a nationwide fee schedule should be established. We are just now getting away from fixed fee schedules in various Government and voluntary pro-

(Continued on page 48)



***"Now that your acne is clearing up nicely,
it might be a good idea if you started losing some weight."***

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain*. When a new dietary pattern must be established, consider the adjunctive use of **BAMADEX SEQUELS**. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, **BAMADEX SEQUELS** controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients

with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex[®] Sequels[®]

Dextro-Amphetamine Sulfate (15 mg.)
with Meprobamate (300 mg.)

Sustained Release Capsules



LEDERLE LABORATORIES

A Division of American Cyanamid Company
Pearl River, New York

407-B

paid medical care programs. We should resist as much as possible the return to fixed fee schedules. A medical fee schedule on a national basis for Medicare and Medicaid programs would be similar to the frozen wages and salaries in force during World War II. Once these are established, it will be very difficult to change them—a good example of which is the attempts made by non-profit prepaid medical care plans to increase fees to physicians participating in their programs.

The Medical profession must do all in its power to control unjustified increases in fees on the part of physicians, unnecessary admissions, and over-utilization of hospital clinical facilities. If we can do this we can preserve the concept of usual and customary fees; if we cannot do it the danger of fixed fee schedules faces us in the future.

William A. Limberger, M.D.
West Chester

Involvement vs. Confusion

*A Hypothetical Community Case History**

A mythical community, population 500,000, is the focus of our discussion. Approximately 1,000 physicians, thirty of whom are psychiatrists, practicing in this city. Each of three local general hospitals has small psychiatric units totaling sixty beds. A child guidance clinic, operated by a pediatrician, is the only resource for children with undue emotional problems. Nearby is a 1,000-bed state mental hospital.

The train of events we are discussing begins with a facility which has not been mentioned: the Public Health Department's Mental Health Clinic. This clinic—staffed by one full-time psychiatrist, one part-time psychiatrist, one psychologist, one social worker, and one vocational rehabilitation counselor—is concerned exclusively with follow-up services for citizens of this city who have been discharged from the state hospital.

A local news story pointed with considerable pride to the fact that in the first three years of operation, this clinic had reduced the readmission rate of local citizens to the state hospital from 60 percent to twenty-five percent. This information became more impressive when it was pointed out that for the past decade, admission to this state hospital from our mythical community had increased at the rate of ten percent per year. Very clearly, this clinic's existence had not altered the rate of admission—only the rate of readmission.

The Mental Health Committee of the United Fund Council reacted quickly to this news. "Expand the function of this clinic," they clamored. "Include early detection and care with outpatient services. Prevent hospitalization!"

You may quickly discern that this committee was chaired by an alert, impetuous person. He was an architect, skilled in his profession, but not limited by it. Having anticipated the conclusion of his state's mental health planning, he had obtained all available demographic data from his State Mental Health Authority and had related it to local survey material developed by his committee. In his enthusiasm, he reorganized and publicized this data which strongly supported

his exhortations to expand mental health services and to prevent hospitalization. Unfortunately, he neglected to credit the source of his information.

The local Medical Society's Mental Health Committee, nettled by this untimely encroachment on their function, challenged the survey as well as the qualification of the local architect to lead this campaign for extended mental health services. The committee met forthwith and recommended that the Medical Society assume leadership in mental health planning for the community. Presuming the survey data collected by the United Fund's Mental Health Committee was invalid, they reluctantly decided to use Medical Society funds to conduct a complete and accurate survey of the mental health needs of their city. They reasoned with mixed feelings that this might result in nothing more than credit for the Society for a responsible and civic-minded gesture. They also sensed a nervous uneasiness about the "third party" implications of this program.

During this series of interchanges between the United Fund Council and the Medical Society, the local Mental Health Association became painfully conscious of being "an outsider looking in" on action clearly keyed to its own avowed purposes and goals. Previously, their group had been preoccupied with educating, arousing, and motivating the public to recognize mental illness in their midst. Each of these groups (Public Health Department, United Fund, Medical Society, Mental Health Association) were pushing to find some role in this growing program. The Mental Health Association and the Medical Society, fusing their efforts, called a public meeting to discuss mental health planning for the community. The Public Health Department's Mental Health Clinic and the United Fund Council's Mental Health Committee, while invited to the meeting, resented and distrusted this coalition and its tactics.

* A report from the A.M.A. 2nd National Congress on Mental Illness and Health presented by Moody C. Bettis, M.D., as adapted by George E. Farrar, Jr., M.D.

Is it depression?
She says "I'm always on edge..."

**...but her other symptoms:
depressed mood, insomnia,
anorexia, feelings of guilt
strongly suggest
an underlying depression.**

when the diagnosis is depression

ELAVIL[®] HCl **(AMITRIPTYLINE HCl | MSD)**

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

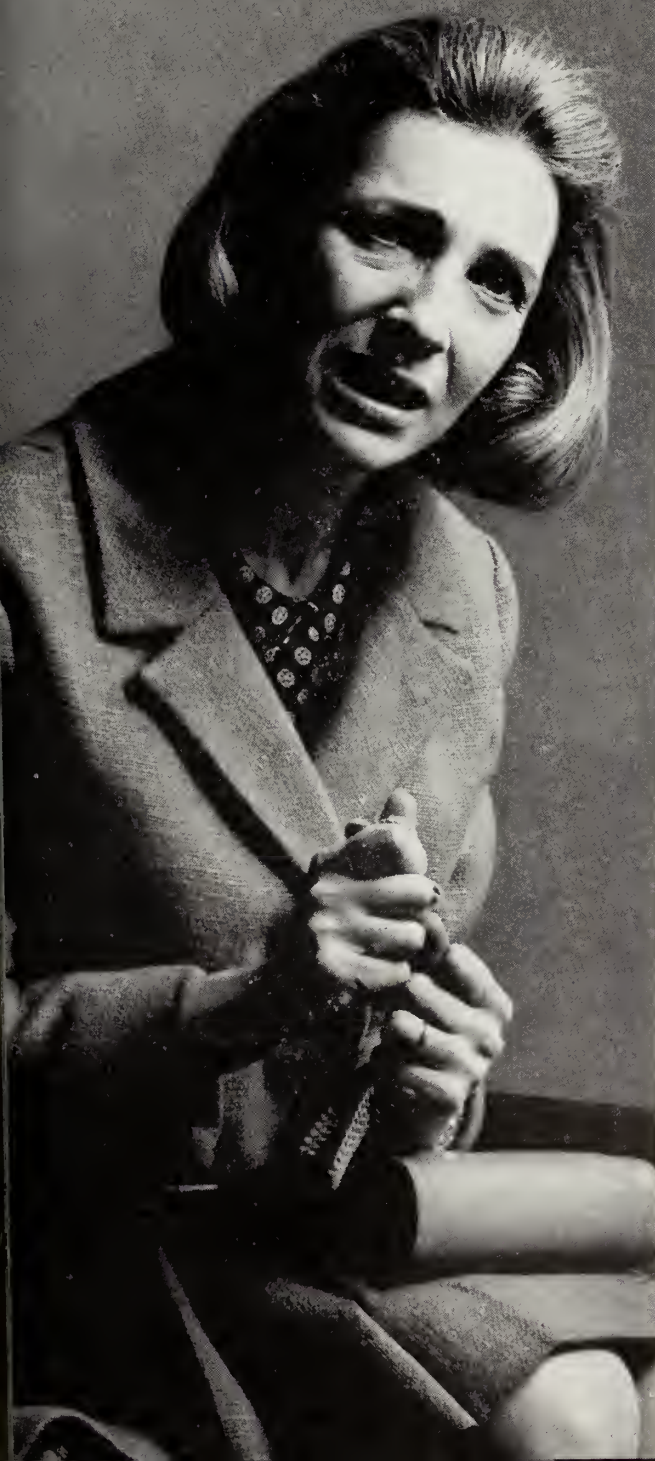
For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.



MERCK SHARP & DOHME

Division of Merck & Co. Inc. West Point Pa 19486

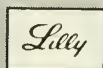
WHERE TODAY'S THEORY IS TOMORROW'S THERAPY





Now...twice as much as before in each teaspoon

400,000 units of potassium penicillin V per teaspoonful
New...V-Cillin K[®], Pediatric, 250 mg.
Potassium Phenoxymethyl Penicillin



Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

800192



Toxicology in the Emergency Room

SEYMOUR SCHOTZ, M.D.
Philadelphia, Pennsylvania

A patient is brought to the emergency room of the hospital with the provisional diagnosis usually supplied by the family that the subject had accidentally (or intentionally) received some poisonous material. The scene is often choked with hysteria. This hysteria takes two

forms: The family is doing a lot of hand-wringing. The question is often repeated "Why did she or he do it?" or "How could it have happened?"—the answers to which often were obvious to anyone close to the patient had they but troubled to see. The second form of hysteria is that which

must inevitably result if the physician in charge does not pursue a logical and disciplined course in the treatment of the patient.

Hysteria No. 1 is of no interest to this particular session. Our purpose is to discuss the approach which

. . . in answering some of the questions . . .

will minimize or eliminate hysteria No. 2.

The treatment of the poisoning victim regardless of the mode involves four disciplines. It is important that these disciplines be taken up in the following order:

1. The care of the respiratory and circulatory systems.
2. The possible evaluation of poisons which may still be lodged in the stomach.
3. Measures for hastening the elimination of the poisons.
4. Measures for neutralizing the effect of the poisons already absorbed—if this is practical.

Regardless of the type of poisoning, attention should *first* be directed to assessing the integrity of the respiratory and cardiovascular systems. If the patient is unconscious and is unable to control his own airway, any measure necessary to establish an efficient airway must be immediately carried out. This might be the simple insertion of an oral pharyngeal or nasopharyngeal tube. If this is not adequate, an oral tracheal or a nasotracheal tube must be inserted. Finally, if this is not practical, a tracheostomy should be performed. The adequacy of pulmonary ventilation should be assessed; where this is inadequate, it should be supplemented by the use of a proper intermittent positive pressure breathing apparatus.

Simultaneously attention should be directed to the rate, rhythm, and character of the pulse. If there is any question about the presence of the femoral or carotid pulse, external cardiac compression should be instituted.

In any case of serious proportions, a plastic needle or catheter should be rapidly inserted into the most readily accessible vein and kept open with a suitable intravenous solution. This acts as an avenue for administering whatever is needed in fluid therapy as well as corrective drug therapy. At this point, if it is necessary, an electrocardiogram should be obtained to establish a diagnosis.

The measures we have mentioned so far apply no matter what the nature of the poisoning.

Gastric lavage is a useful procedure for removing whatever is still in the stomach. There are two matters of caution however. When the poison is a strong acid or alkali, it may be wise to avoid inserting a stomach tube for fear of perforating the esophagus. Secondly, whenever the patient is unconscious, an endotracheal tube with an inflatable cuff should be inserted prior to passing the stomach tube. This is necessary to protect the patient from vomiting and aspirating stomach contents.

In general those substances such as central nervous system depressants which exert their effect in proportion to their concentration in the blood can be removed by vigorous diuresis. As much as 600 cc of fluid may be given per hour as long as the urine volume is within 1,200 cc of the intravenous intake per day. Mannitol is a useful agent to promote diuresis. To protect against circulatory overload, it is wise to measure and record the central venous pressure. Since there is some evidence that phenothiazine derivatives may, after absorption, be resecreted into the stomach, it is wise in these cases to insert a Levine tube and maintain constant suction. Those substances such as acetylsalicylic acid which in overdose can produce severe acidosis have to be treated by the giving of suitable amounts of a buffering alkali. The only adequate method of handling is the frequent analysis of the arterial blood to assess the patient's needs. Such determinations on anaerobically drawn arterial blood are much preferable to the more commonly performed carbon dioxide combining power.

To attempt to list here all the measures to be taken under any and all types of poisoning would be outside the scope of this discussion. I should strongly recommend that if you have opportunity to attend victims of poisoning that you carry with you a very handy volume on the subject. This is a small textbook, small enough to be carried in the pocket or certainly

in the handbag of any practitioner. It is entitled *The Hand-book of Poisoning* by Robert Dreisbach.

A more detailed consideration of these problems is available in either of the following two texts, *Poisoning* by Sven Moeschlin, (Grune and Stratton, New York City, 1965) and *Clinical Toxicology* by Gleason, Gosselin, and Hodge (Williams and Wilkins, Baltimore, 1963). Both volumes are excellent works. The latter is especially recommended for all hospital emergency services. It contains a very detailed account of practically every known commercial and medicinal poison and is carefully cross-indexed. It has an excellent treatise dealing with general measures and specific measures for each poison. I find myself in sharp disagreement with their recommendations on the proper management of barbiturate poisoning. But aside from this, it is a most valuable work. Finally, each doctor has on his desk or close at hand a work which can be of great use in answering some of the questions dealing with medicinals which have been taken in overdose. This is the *Physicians Desk Reference* published by Medical Economics.



■ Dr. Schotz is director of the department of anesthesiology at Presbyterian-University of Pennsylvania Medical Center.

Pituitary Stalk Section:

*A non-hazardous
treatment
for diabetic
retinopathy*

Since Poulsen¹ described a patient in 1953 illustrating the Houssay phenomenon with a favorable effect on diabetic retinopathy, a variety of methods have been proposed to interfere with pituitary function for this purpose. It is a general reaction that the intracranial approach to the pituitary gland is particularly hazardous in these patients and any other approach, *a priori*, is to be preferred. Reports continue to appear, tacitly assuming any mortality and morbidity of the transsphenoidal approach must be distinctly lower than with any intracranial procedure. It is our opinion however that, as of now, hypophyseal stalk section through a small transfrontal craniotomy is the simplest method to interfere with pituitary function. It has an operative mortality which compares favorably with any other method and we wish to emphasize that it is the method attended by the fewest and least dangerous post-operative complications. This opinion is based upon our experience with twenty-one patients and a review of the literature.

Material and Methods

Twenty-one patients with progressive diabetic retinopathy were selected for hypophyseal stalk section from October, 1964 through February, 1967 (TABLE I). There were eight females and thirteen males with the average age being 44.7 years (range, 17 to 64). Seven can be considered juvenile diabetics (age of onset before fifteen). Diabetes had been known to have been present at least nine years in all patients and for as long as sixty years in one patient. Visual symptoms had been present for five years in one patient, but usually had been complained of for only six to twelve months prior to surgery.

I. Visual Criteria for Selection

Progressive retinopathy threatening loss of useful central vision was the most important criterion for surgical intervention. Patients with advanced neo-vascularization, fibrotic changes and active hemorrhagic tendency were acceptable provided one macula was still intact or not irre-

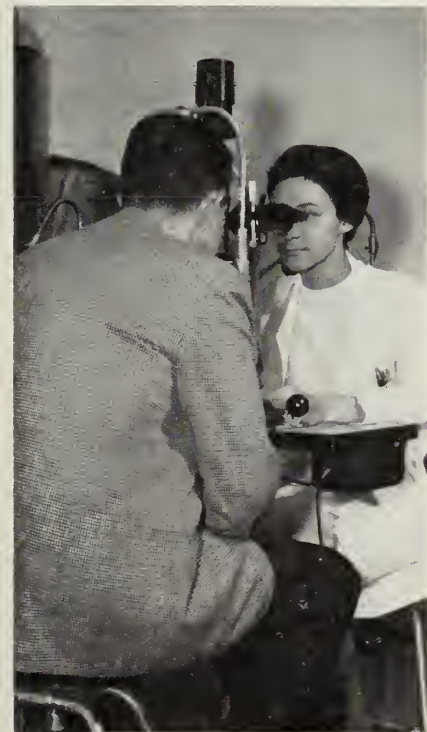
versibly changed. Patients were rejected with bilateral complete irreversible macular destruction, massive vitreous hemorrhage, or retinopathy in which hemorrhagic phenomena were not a major factor. In four cases in which these criteria were relaxed, that is, there was advanced proliferative disease bilaterally, the retinopathy progressed to blindness despite good evidence for surgical production of hypopituitarism in three.

II. Medical Criteria for Selection

Patients with advanced diabetic nephropathy were rejected. However, eleven patients with moderate elevations of blood urea nitrogen were accepted for surgery when the creatinine clearance in each was found to be 60 ml./min. or more and the azotemia of each of these patients proved not to be fixed. Patients with persistent cardiomegaly, myocardial ischemia, refractory congestive heart failure, or fixed arrhythmia or hypertension were rejected as candidates. Five patients with a history of hypertension (two with left ventricular hypertrophy on ECG and one patient each with compensated congestive heart failure and previous myocardial infarction) were included among the patients. Three patients had previous amputation for diabetic peripheral vascular disease.

III. Operative Procedure

In all cases the stalk section was performed through a small transfrontal craniotomy on the side showing the more advanced retinopathy. Mannitol (400-500 cc) was given intravenously over a ten minute period thirty to sixty minutes prior to surgery. An indwelling spinal needle was placed in the lumbar subarachnoid space for spinal drainage. The frontal lobe was then elevated, and the chiasmatic cistern entered and drained to provide further brain relaxation. The pituitary stalk was exposed and sectioned close to the diaphragma sellae between silver clips. A piece of gold foil was placed over the sella in an effort to prevent regrowth of the hypothalamic-hypophyseal portal system. The position of the gold foil was checked by x-ray postoperatively in all cases. The frontal sinus when



HENRY A. SHENKIN, M.D.
PAUL GUTTERMAN, M.D.
ALBERT J. FINESTONE, M.D.
Philadelphia, Pennsylvania

entered must be sealed off with great care. Fortunately this was always possible. In later cases, recognizing we were not invariably producing obvious hypopituitarism after stalk section had been accomplished, the sella was entered with a spatula several times, sufficient to traumatize the gland, but no effort was made to remove it. Hypopituitarism was produced in all these patients. The following was used as evidence that hypopituitarism had been achieved: (1) Distinct decrease in insulin requirement (2) Loss of menses; and libido and potentia in the male (3) Inability to function without replacement therapy.

Results

I. Postoperative Course

There was no surgical mortality in

twenty-one cases. All patients were ambulated in twenty-four hours. Intravenous feedings were continued only for the immediate postoperative periods using 5 percent glucose and water and generally supplying 150 grams of carbohydrates for the first twenty-four hours postoperatively. Patients taking depot insulin preoperatively generally had this type of insulin continued, including the day of surgery, with small supplementary doses of regular insulin in the immediate postoperative period if glycemia became significant. No effort was made to achieve normoglycemia during this period. Patients on oral agents had this type of medication discontinued on the day of surgery and some received small doses of regular insulin in the immediate postoperative period, again depending on

significant glycemia. The oral medication was resumed usually by the third to fifth day. Diabetic management was surprisingly smooth and uncomplicated even though an initial dose of 75 mgm of hydrocortisone was given every six hours and then reduced to maintenance (10 mgm t.i.d.) by the seventh postoperative day. No significant problems with acidosis or hypoglycemia were encountered.

Transient increase in urinary output was noted in eight patients. Only two of these required injections of pitressin during the early postoperative period. Two patients persisted with excessive urinary output lasting six and eighteen months and lysine vasopressin was prescribed by inhalation for its control. There has been no permanent diabetes insipidus.

TABLE 1. Summary of Patients and Results of Stalk Section for Diabetic Retinopathy.

Patient Age Sex	Age At Onset Diabetes	Duration Visual Symptoms	Pre-Op Visual Picture	Post-Op Visual Picture	Cardio- Renal Disease	Post-Op Pituitary Insufficiency	Insulin Change	Complications	Late Mortality
M.O. 26 F	10	2 yr.	Hemorrhages Exudates Both Eyes	Improved	No	Yes	No	Transient Increase Urine	
M.D. 37 F	22	2½ yr.	O.D. Marked Proliferation O.S. Hemorrhages	Worse	LVH Proteinuria BUN Normal	Yes	Decreased	Transient Rhinorrhea	
R.C. 42 M	25	½ yr.	O.D. Proliferation Macular Obliteration O.S. Hemorrhages Exudates	Worse	Hypertension BUN Increased Proteinuria	Yes	Decreased	Transient Rhinorrhea	Pulmonary Embolus
J.R. 64 M	60	½ yr.	Advanced Proliferation Both Eyes	Worse	Myocardial Disease	Yes	Oral Agents	None	
E.L. 46 M	46	½ yr.	O.D. Hemorrhages Exudates O.S. Marked Proliferation	No Progress	Hypertension BUN Increased	Yes	Decreased	Post-Op. Seizures	
F.S. 40 F	15	5 yr.	O.D. Marked Proliferation O.S. Hemorrhages	Improved	Hypertension	Yes	Decreased	Transient Increase Urine	
E.S. 51 M	32	1 yr.	O.D. Minimal Changes O.S. Hemorrhage Neovascular	No Progress	BUN Increased	Yes	No Change	Transient Increase Urine	
J.H. 34 M	9	1 yr.	O.D. Hemorrhage O.S. Marked Proliferation	Worse	BUN Increased	Yes	No Change	Transient Increase Urine	
B.P. 50 F	50	½ yr.	Advanced Proliferation Both Eyes	Worse	BUN Increased Proteinuria	Yes	None Pre-Op.	None	
E.L. 47 M	29	½ yr.	Advanced Proliferation Both Eyes	Worse	Hypertension BUN Increased	Yes	Decreased	Transient Increase Urine	
W.R. 40 M	40	½ yr.	O.D. Early Prolif. Hemorrhages O.S. Hemorrhages Exudates	No Progress	No	Yes	Decreased	None	
F.C. 34 F	11	½ yr.	O.D. Marked Proliferation O.S. Hemorrhages	Worse	No	Yes	Decreased	Diabetes Insipidus To 18 Months. None At Present	
A.K. 55 F	31	2 yr.	Hemorrhage Exudate Both Eyes	Worse	BUN Increased Proteinuria	Yes	Decreased	Post-Op. Seizures Wound Infection	
A.G. 44 F	10	5 yr.	O.D. Hemorrhages O.S. Minimal Changes	Improved	No	Yes	Decreased	Rhinorrhea	
R.M. 17 M	3	½ yr.	Hemorrhages Microaneurysms Both Eyes	Improved	Hypertension BUN Increased Proteinuria	Yes	Decreased	Transient Increase Urine	
H.G. 53 M	52	1 yr.	Hemorrhage Exudates Both Eyes	No Progress	No	Yes	None Pre-Op.	Transient Increase Urine	Acute Myocardial Infarction
S.V. 44 M	40	1 yr.	O.D. Advanced Proliferation O.S. Large Vitreous Hem.	Worse	BUN Increased	No	None Pre-Op.	None	Unknown Cause
D.L. 30 M	14	½ yr.	O.D. Hemorrhage O.S. Marked Proliferation	Worse	Low Clearance	No	Increased	None	
J.S. 56 M	37	½ yr.	O.D. Neovascular Changes Exudates O.S. Large Vit. Hemorrhage	Worse	LVH Hypertension Heart Failure BUN Increased	No	None Pre-Op.	None	
L.G. 49 F	27	1 yr.	O.D. Hemorrhages O.S. Marked Proliferation	Worse	Old Myocardial Infarct	No	Increased	None	Acute Myocardial Infarction
J.O. 49 M	46	1½ yr.	Hemorrhages Proliferation Both Eyes	Worse	No	No	No Change	None	

Persistent cerebrospinal fluid rhinorrhea due to entering the frontal sinus occurred in one patient. The leak was closed without difficulty one week postoperatively. Rhinorrhea was reported by two patients in the immediate postoperative period but did not persist after seventy-two hours. There were no instances of meningitis.

Two patients developed convulsions postoperatively; one episode was thought to be related to hyponatremia. Neither patient has had a seizure since discharge from the hospital (eighteen and thirty months respectively) despite cessation of anticonvulsant medication.

Electrolyte disturbances were noted in three of our patients six to ten days postoperatively and were controlled without difficulty. A transient low grade temperature elevation was noted in the immediate postoperative period in eight patients, but no infections were recognized. However, a persistent wound infection developed in one patient six months postoperatively.

Overall, the postoperative course was most benign. All patients were

ambulated within twenty-four hours and following stabilization of their insulin and hydrocortisone requirements, were discharged in ten to fourteen days. The majority of patients (twelve of fifteen) reported an improved overall sense of well being in the late postoperative period.

Eleven patients had evidence of preoperative renal dysfunction and the ECG was abnormal in five of the twenty-one cases. All of these patients tolerated operation well, and there were no episodes of coronary insufficiency or cardiorenal decompensation during the postoperative period. One patient, without evidence of previous cardiac abnormality, developed an arrhythmia that has been controlled with medication through a twenty-four month postoperative period.

During the follow up period of three years there have been four deaths among our patients. Two deaths occurred in patients without evidence of modification of pituitary function: one of a pulmonary embolus three months postoperatively and the other of unknown causes two years after stalk section. Two patients died of myocardial infarction eighteen and

twenty-four months postoperatively. One of these patients had had a myocardial infarction previously.

II. Effect on Diabetic Control and Insulin Requirement

Six of the seven juvenile diabetics achieved an alteration of pituitary function by our criteria and the insulin requirement was decreased in three and has been unchanged in three. There have been no episodes of acidosis postoperatively in any of these patients even though there had been documented episodes of diabetic acidosis in two prior to stalk section. The tendency to hypoglycemic episodes has been less frequent in five of the six patients. The sixth patient had been having more frequent episodes of hypoglycemia and had been much more difficult to control for eighteen months postoperatively. Since then however, now a matter of eight months, her control has improved.

Seven of the nine adult diabetic patients with good evidence for postoperative pituitary interference were taking insulin prior to surgery. One patient had been on diet control alone

TABLE 2. Summary of Results of Stalk Section Previously Reported.

	Number of Patients	Surgical Mortality	Vision Improved	Vision Stabilized	Vision Worse	Hypoglycemic Reaction	CSF Rhinorrhea	Meningitis	Other Complications
Gordon et al. ^{2, 5} (1962)	5	2	1	2	0	1*	0	0	Intracerebral Hematoma
Lundbaeck et al. ⁴ (1962)	2	0	0	1	1	0	0	0	
Flohr and Maxwell ⁶ (1963)	1	0	0	0	1	0	0	0	
Cullen et al. ⁹ (1965)	7	0	3	3	1	0	0	0	
Kjellberg, Sweet et al. ⁷ (1965)	105	2	← 54 →		13	0	0	0	
Speakman et al. ⁸ (1966)	8	2	4	0	3	3(1*)	0	0	Intracerebral Hematoma
Fager et al. ⁹ (1966)	29	1(?)	10	3	12	0	0	0	2 Adrenal Failure
Rucker et al. ¹⁰ (1967)	33	0	16	11	6	2*	0	0	1 Seizure
Shenkin et al. (1967)	21(16)	0	4	4	8	0	3	0	2 Seizures
Total	211	7	← 116 →		45	6(4*)	3	0	

* Caused death.

TABLE 3. Summary of Results of Hypophysectomy Previously Reported.

	Number of Patients	Surgical Mortality	Vision Improved	Vision Stabilized	Vision Worse	Hypoglycemic Reaction	CSF Rhinorrhea	Meningitis	Other Complications
Luft et al. ^{11, 12} (1956)	20	5	7	3	2	1	—	—	1 Seizure 1 Septicemia
Schimer et al. ¹³ (1956)	5	0	2	3	0	0	0	0	
Kinsell ¹⁴ (1957)	9	0	2	0	0	1	0	0	7 Late Deaths Uremia
Moore ¹⁵ (1957)	1	1	0	0	0	0	0	0	1 Cerebral Infarct
Auderssen and Kjeruff ¹⁶ (1958)	2	0	2	0	0	0	0	0	
Slater ¹⁷ (1958)	3	1	2	0	0	—	—	—	
Vannas et al. ¹⁸ (1959)	10	1	3	4	3	0	0	1	5 Visual Field Cuts 1 Brain Abscess 1 Severe Orthostatic Hypotension
Londhaeck et al. ⁴ (1962)	4	0	2	1	1	0	0	1	
Gordon and Javid ² (1962)	17	4	7	2	0	4	0	0	
Bryan ¹⁹ (1962)	7	2	0	2	0	1	0	0	
Ainslie et al. ²⁰ (1962)	7	1	5	0	1	0	0	0	
Giroux et al. ²¹ (1963)	1	0	1	0	0	0	0	0	2 Seizures
Pearson et al. ²² (1964)	14	3	← 8 →		3	1	0	0	
Chow ²³ (1964)	4	0	2	2	0	—	—	—	
Williamson ²⁴	4	1	0	3	0	—	—	—	
Ray et al. ²⁵ (1965)	42	4	18	5	8	0	1	0	
Fager et al. ⁹ (1966)	23	—	14	2	6	—	—	—	
Total	173	23	← 102 →		24	8*	1	2	

* Caused death.

and the ninth of this group of patients had been controlled by diet and tolbutamide. The insulin requirement in the group using it has been decreased in six patients and abolished in the seventh. There had been some difficulties with hypoglycemia episodes in the initial postoperative period in three of the patients, but this was easily overcome by adjustment of their insulin dosage.

III. Ophthalmologic Picture

Overall, the visual acuity of four patients was improved, and the progress of visual deterioration was stopped in an additional four patients one to three years postoperatively. The operation therefore was worthwhile in 38 percent of the patients (TABLE I); however, the five patients who lacked definite evidence of hypopituitarism continued to have progressive visual deterioration postoperatively. If we exclude these five cases, the procedure was then successful in eight of sixteen patients (TABLE I). If we eliminate the patients whose eye changes were such that no help for them could be anticipated, as discussed above, and those without evidence of hypopituitarism, then eight of thirteen patients (62 percent) had improvement or stabilization of their visual status.

There was stabilization or amelioration of vision in three of six pa-

tients under forty years of age and in five of ten patients over forty years of age. However, there was improvement or maintenance of useful visual acuity in five of six juvenile diabetics and in only four of ten patients with onset of diabetes after the age of fifteen. These results imply that successful retardation of the progressive diabetic retinopathy in our series was not dependent on the age of the patient at the time of surgery but that stalk section was somewhat more successful in the juvenile diabetic.

A most important factor for the success of stalk section for vision is the preoperative ophthalmologic picture. Three patients with apparently successful pituitary interference had marked proliferative changes and were legally blind preoperatively (visual acuity of 20/200 or less), and they showed no improvement following surgery. Indeed, at this time we would not consider these patients candidates for this procedure. Eight patients with successful interference of pituitary function had extensive proliferative changes in one eye but the other eye showed principally hemorrhagic and exudative changes with neo-vascularization, and three either improved or had stabilization of their ophthalmologic picture. The five patients who showed hemorrhages, exudates and neo-vascularization with the absence of, or only minimal, prolifera-

tive changes in one or both eyes all were similarly helped.

Review of Literature

One hundred ninety patients subjected to pituitary stalk section for diabetic retinopathy have been reported previously in eight individual series (TABLE II). Including the present series there were seven deaths (3.3 percent) in the immediate postoperative period. The operation produced stabilization or amelioration of the retinopathy in one hundred sixteen of one hundred seventy three patients, for an overall benefit of 67 percent. There were four additional late deaths due to hypoglycemic reactions and two more late deaths due to adrenal failure. Convulsive seizures were reported in only three patients. Permanent diabetes insipidus was rarely noted.

Hypophysectomy by means of craniotomy for diabetic retinopathy has been reported in 173 patients in seventeen series (TABLE III). There were twenty-three deaths in the immediate postoperative period (13.3 percent). In addition, eight delayed deaths were reported due to hypoglycemic episodes. The total ablation of the pituitary gland by means of craniotomy was worthwhile in 102 of the 149 patients with ophthalmological results reported (68.4 percent). All patients were more liable to hypogly-

TABLE 4. Summary of Results of Transsphenoidal Hypophysectomy Previously Reported.

	Number of Patients	Surgical Mortality	Vision Improved	Vision Stabilized	Vision Worse	Hypoglycemic Reaction	CSF Rhinorrhea	Meningitis	Other Complications
Lundbaeck et al. ¹ (1962)	8	0	2	4	2	0	0	1	1 Injury to Carotid Artery
Sjogren ²⁰ (1962)	26	2	1	13	4	3*	0	0	1 III Nerve Palsy
Teuscher ²⁷ (1963)	8	0	2	3	3	—	—	—	—
Harrold et al. ²⁸ (1965)	15	0	5	3	4	0	1	1	Bleeding from Cavernous Sinus
Scott ²⁹ (1966)	18	2	3	8	2	0	3	1	Hemorrhage from Ophthalmic Artery
Fankhauser et al. ³⁰ (1966)	8	0	0	4	4	2*	0	0	—
Speakman et al. ⁸ (1966)	18	0	11	4	3	3	1	2	—
Total	101	4	24	39	22	8(5*)	5	5	—

* Caused death.

TABLE 5. Summary of Results of Transsphenoidal Vitrium Implantation Previously Reported.

	Number of Patients	Surgical Mortality	Vision Improved	Vision Stabilized	Vision Worse	Hypoglycemic Reaction	CSF Rhinorrhea	Meningitis	Other Complications
Scott ³¹ (1962)	1	0	1	0	0	—	—	—	—
Luff et al. ³² (1964)	11	0	4	2	0	2*	0	1	—
Kodejszko et al. ³³ (1964)	5	0	1	0	2	—	—	—	—
Cullen et al. ³⁴ (1965)	10	1	6	2	0	0	2	1	—
Joplin and Fraser ³⁵ (1965)	38	0	9	9	1	0	8	4	8 Severe Diabetes Insipidus
Pearson ³⁶ (1965)	25	0	17	—	—	0	1	1	—
Sedan et al. ³⁷ (1965)	18	—	4	10	1	—	—	—	—
Ray ³⁸ (1965)	18	3	9	—	—	—	6	5	1 Bitemporal Field Cut
Total	126	4	51	23	4	2*	17	12	—

* Caused death.

cemic episodes and were completely dependent on cortisone and thyroid replacement.

Hypophysectomy by the transsphenoidal route was performed on 101 cases in seven reports (TABLE IV). The mortality in the immediate postoperative period was only 4 percent. There was either improvement or stabilization of the retinopathy in sixty-three of eight-nine patients (71 percent). Cerebrospinal fluid rhinorrhea was reported in five patients and meningitis in five patients. Hypoglycemia also was a frequent problem following this procedure just as occurred after hypophysectomy via craniotomy and was the cause of death in five patients. Other significant complications were hemorrhage from the cavernous sinus, from an ophthalmic artery, injury to the carotid artery causing a hemiparesis, and an extraocular palsy, each in one patient.

Transsphenoidal implantation of yttrium-90 into the pituitary gland has been reported in 126 patients in eight series with good effect on vision in almost all cases in which ophthalmological results are reported (TABLE V). Joplin *et al.*³⁵ in 1965 noted that the variable levels of radiation to the pituitary gland caused endocrine effects that varied considerably. As with the transsphenoidal approach to surgical hypophysectomy the associated morbidity due to cerebrospinal fluid leak is frequent, reported in seventeen of one hundred eight cases (15.7 percent). Meningitis was reported in twelve cases (9. 4 percent) and was the cause of delayed death in six cases.

Heavy particle irradiation with the proton beam has been reported in two hundred sixteen patients in three series (TABLE VI). The effects of the

destruction of the pituitary gland were delayed in onset, and the degree of destruction again was variable, producing a severely endocrinologically damaged individual in some cases and inadequate destruction in other cases. The procedure has been reported effective from the ophthalmological point of view in 62 percent to 71 percent of the one hundred ninety eight reported results. There was no immediate mortality but extraocular palsies were noted in 4 percent of patients in one series and in 22 percent and 40 percent of patients in the other two series. There was no other significant complication reported.

Treatment of diabetic retinopathy by direct x-ray irradiation to the pituitary gland was reported by Oosterhuis *et al.*⁴¹ in 1963, with improvement or stabilization of retinopathy in six of eleven patients. The authors concluded, however, that the severe mental deterioration in three patients due to radiation gliosis of the brain ruled out this method of treatment.

Recently, Adams, Rand *et al.*⁴² reported the results of transsphenoidal cryohypophysectomy in fifteen patients with diabetic retinopathy. They reported improvement or stabilization in twelve of the fifteen patients and two deaths due to cardio-renal complications. They noted that the procedure was done under local anesthesia and that there was no morbidity. However, in another series of twenty-five cryogenic transsphenoidal hypophysectomies reported by Bleasel and Lazares⁴³ in 1965 for multiple causes, the authors noted rhinorrhea in one case, meningitis in two cases, visual field cuts in three cases and extraocular palsies in three cases. Similar difficulty with rhinorrhea was reported by Conway and Collins⁴⁴ in 1965 and Wilson *et al.*⁴⁵ in 1966.

At the Sixth Congress of the International Diabetic Federation Zervas *et al.*⁴⁶ reported a series of eighty-four patients on whom they performed a radio-frequency hypophysectomy by the transsphenoidal approach for various disorders. Twenty-one of these patients had progressive diabetic retinopathy. They reported four cases of rhinorrhea and one death due to ensuing meningeal infection five months postoperatively.

Discussion

Successful interference with pituitary gland function by pituitary stalk section was produced in sixteen of twenty-one patients and resulted in an improvement or stabilization of vision in eight of the thirteen patients in this group of sixteen whose ophthalmologic changes, in retrospect, could possibly be reversed by surgery. There was no operative mortality and a postoperative complication was noted in only three patients. The complications were easily overcome and proved to be of no permanent consequence. Postoperative hypoglycemic episodes proved to be no serious problem and in the majority of the juvenile diabetics they were reduced in frequency. In view of the fact we were dealing with a group having a high incidence of cardiovascular-renal disease, the minimal incidence of postoperative morbidity and no mortality emphasizes the minimal stress this procedure places upon these patients. Modern improvements in anesthetic and craniotomy techniques, reducing operative time to an average of about one hour, no doubt contribute heavily to the relative safety of this procedure. An especially important factor, in our view, is the preoperative use of mannitol. Not only does it serve to reduce intracranial tension, easing the approach to the sella, but it also increases the cerebral circulation, thus protecting the patient against cerebrovascular insufficiency during the operative procedure.⁴⁷ Initially, we were not always successful in producing clinical evidence of hypopituitarism by stalk section alone, but it is likely that this can be achieved consistently by adding direct trauma to the gland itself, after section of the stalk. This does not add to the risks of the operation and does not completely infarct the pituitary so as to produce the effects of a total hypophysectomy.

The review of the literature reveals that all proposed methods for interference with pituitary function were

TABLE 6. Summary of Results of Heavy Particle Irradiation, X-Ray, Cryohypophysectomy and Radiofrequency Hypophysectomy. Previously Reported.

Heavy Particle Irradiation	Number of Patients	Vision Improved	Vision Stabilized	Vision Worse	Complications
Sangalli ³⁹ (1961)	18	45% 4 pts.	22% 2 pts.	33% 3 pts.	40% Extraocular Palsy
Lawrence <i>et al.</i> ⁴⁰ (1963)	71	23% 14 pts.	39% 24 pts.	38% 23 pts.	3 Extraocular Palsy
Kjellberg <i>et al.</i> ⁷ (1965)	127	37%	34%	29%	28 Extraocular Palsy
Total	216	62% → 71%		29% → 38%	

X-Ray	Number of Patients	Vision Improved	Vision Stabilized	Vision Worse	Complications
Oosterhuis <i>et al.</i> ⁴¹ (1963)	11	3	3	5	Radiation Necrosis—Three Patients
Transsphenoidal Cryohypophysectomy					
Transsphenoidal					
Adams, Rand <i>et al.</i> ⁴² (1967)	15	10	2	3	
Radiofrequency					
Zervas <i>et al.</i> ⁴³ (1967)	21	—	—	—	Rhinorrhea—4 cases Meningitis—1 case

successful in improving or stabilizing the vision of patients suffering from diabetic retinopathy in from 62 percent to 71 percent of patients. One method does not appear to be any more successful than any of the others in producing this visual result.

Total hypophysectomy, either by the intracranial or transsphenoidal approach, has the highest operative mortality and postoperatively patients require considerably more attention than after stalk section. This is due to the propensity to hypoglycemic crises and more profound endocrine disturbances. Transsphenoidal implantation of yttrium is performed most frequently under general anesthesia and seemingly requires a longer time to accomplish than does stalk section. The particular hazards of this approach are postoperative rhinorrhea and meningitis and the difficulty to control accurately the amount of destruction to the pituitary gland and surrounding tissues. Transsphenoidal cryogenic and radio-frequency hypophysectomy are probably more easily controlled methods for producing hypopituitarism, but the postoperative complications of rhinorrhea and meningitis remain. Reports concerning these methods are still meager but it is already apparent the techniques are different if not frequently impossible to complete under local analgesia alone and they are not yet completely controllable. Damage to the optic chiasm, nerves to the extraocular muscles and the hypothalamus have been reported with destruction of the pituitary gland remaining variable. Heavy particle irradiation certainly has a lower mortality and morbidity than any of the surgical methods but its lack of general availability and the variable and delayed onset of hypopituitarism are major drawbacks. Deterioration of vision in diabetic retinopathy is frequently rapid and a delay of one or more months in the onset of hypopituitarism may frequently be too slow to be useful.

Therefore, as of this writing, it appears that pituitary stalk section is as safe a procedure as is available, with the most benign postoperative course, and in properly selected cases of diabetic retinopathy has a fair chance to arrest this potentially blinding disorder.

Addendum

Since submission of this report four additional patients have been subjected to pituitary stalk section with similar results.

REFERENCES

1. Poulsen, J. E.: Houssay phenomenon in

man; recovery from retinopathy in a case of diabetes with Simmond's disease, *Diabetes* 2: 7-12 1953.

2. Gordon, E. S., and Javid, M.: Metabolic studies in hypophysectomy for diabetic vascular disease, *Diabetes* 11: 470-472 1962.

3. Javid, M., Gordon, E. S. and Erickson, T. C.: Hypophysectomy in severe diabetics, *J. Neurosurgery* 15: 504-511 1958.

4. Lundbaeck, K., Malmros, R., Andersen, H. C., Orht, V., and Jensen, V. A.: Hypophysectomy for diabetic angiopathy, *Diabetes* 11: 474-479 1962.

5. Flohr, L. J., and Maxwell, H. W.: Pituitary stalk section in treating advanced diabetic retinopathy, *Texas Jnl. Med.* 59: 1091-1094 1963.

6. Cullen, J. F., Harris, P., Munro, J. F., and Duncan, L. J. P.: Pituitary stalk section for advancing diabetic retinopathy, *Brit. Jnl. Oph.* 49: 393-404 1965.

7. Kjellberg, R. N., Andreas, M., Koehler, A., Preston, W. M., and Sweet, W. H.: Hemorrhagic diabetic retinopathy: treatment by pituitary stalk section or by pituitary irradiation with protons at the Bragg peak, *Neur. Med-Chir* 7: 1-13, 1965.

8. Speakman, J. S., Mortimer, C. B., Briant, T. D. R., Ezrin, C., Loughbeed, W. M., and Clarke, W. T. W.: Pituitary ablation for Retinopathy, *Canad. Med. Ass. Jnl.*, 94: 627-635 1966.

9. Fager, C. A., Rees, S. B., and Bradley, R. F.: Surgical ablation of the pituitary in the treatment of diabetic retinopathy, *J. Neurosurgery* 24: 727-734 1966.

10. Rucker, C. W., Gastineau, C. F., and Svien, H. J.: Effect of section of pituitary stalk on diabetic retinopathy, *Mayo Clin. Proc.* 42: 409-416 1967.

11. Luft, R., Olivecrona, H., Ikkos, D., Kornerup, J. and Junggren, H. L.: Hypophysectomy in man: further experiences with severe diabetes mellitus, *Brit. Med. Jnl.* 2: 752-756 1955.

12. Luft, R.: Use of hypophysectomy in juvenile diabetes mellitus with vascular complications, *Diabetes* 11: 461-462 1962.

13. Schimek, R. A.: Hypophysectomy for diabetic retinopathy, *Arch. Ophthalmology* 56: 416-425 1956.

14. Kinsell, L. W.: Hypophysectomy in patients with diabetic vascular disease, *Diabetes* 11: 473 1962.

15. Moore, C. V.: Surgical hypophysectomy for diabetic retinopathy, *Am. J. Med.* 22: 949-960 1957.

16. Anderssen, E., and Kjeruff, K.: Hypofysectomi ved saer diabetes medudalt retinopathi, *Ugeskrift for Laeger* 120: 700-702 1958.

17. Slater, cited by Chow, R. M.: Hypophysectomy in the treatment of diabetic retinopathy, *J. Kansas Med. Soc.* 65: 78-82 1964.

18. Vannas, S., Hernberg, C. A., Bjorkestein, G.: Hypophysectomy as a therapeutic method for proliferative diabetic retinopathy, *Arch. Ophthal.* 62: 370-380 1959.

19. Bryan, J. B.: Hypophysectomy in Patients with Diabetic Oculovascular and Renal Sequelae, *Diabetes* 11: 472 (Nov.-Dec.) 1962.

20. Ainslie, D., Logue, V., and Nabarro, J. D.: Surgical hypophysectomy for diabetic retinopathy, *Diabetes* 11: 463-464 1962.

21. Giroux, J. C., Dennerly, J. M., Hazel, B., Gratton, A., Charbonneau, R., and Lauthier, A.: Hypophysectomie et retinite diabetique, *Un Med. Du Canada* 92: 1292-1296 1963.

22. Pearson, O. H., Ray, B. S., McLean, J. M., Peretz, W. L., Greenberg, E., and Pazianos, A.: Hypophysectomy for treatment of diabetic retinopathy, *JAMA* 188: 108-122 1964.

23. Chow, R. M.: Hypophysectomy in treatment of diabetic retinopathy *J. Kansas Med. Soc.* 65: 78-82 1964.

24. Williamson cited by Chow, R. M.: Hypophysectomy in the treatment of diabetic retinopathy, *J. Kansas Med. Soc.* 65: 78-82 1964.

25. Ray, B. S., Peretz, W. L., Pazianos, A. G., Greenberg, E., McLean, J. M., and Batty, S.: Hypophysectomy in diabetic retinopathy, read before the Harvey Cushing Society Meeting, New York, New York, April 11-15, 1965.

26. Sjogren, B.: Effect of hypophysectomy on diabetic retinopathy, *Diabetes* 11: 479-481 1962.

27. Teuscher, A.: L'hypophysectomie pour diabete grave, *Confin. Neurol.* 23: 285-293 1963.

28. Harrold, B. P., Gough, K. R., Talloh, C. G., Cates, J. E., and James, J. A.: Use of transsphenoidal hypophysectomy in diabetic retinopathy, *Brit. Med. J.* 2: 727-731 1965.

29. Scott, J. K.: Transsphenoidal hypophysectomy for diabetic retinopathy, *Arch. Otolaryng.* 84: 77-81 1966.

30. Fankhauser, S., Teuscher, A., Konig, H., and Reubi, F.: Hypophysectomy for treatment of advanced diabetic retinopathy, *Helv. Med. Acta* 33: 22-28 1966.

31. Scott, cited by Sedan, R. and Harte, M.: Irradiation interstitielle hypophysaire dau le retinopathie diabetique, *Neurochirurgie* 12: 209-225 1966.

32. Luff, R. and Notter, G.: Preliminary results from treatment of juvenile diabetes with progressive vascular complications and neuropathy by implantation of the hypophysis with radioactive Yttrium, *Acta Isotop.* 4: 387-398 1964.

33. Kodejszko, E., Szyzyk, A., and Gorski, C.: Adrenalectomy and radioactive hypophysectomy in treatment of diabetic retinopathy, *Excerpta Medica (International Congress Series)* 74: 26 1966.

34. Cullen, J. F., Harris, P., Turner, J. W., Donaldson, A. A., Munro, J. F., and Duncan, L. J. P.: Pituitary ablation by Y⁹⁰ implantation for advancing diabetic retinopathy, *Brit. J. Ophthal.* 49: 405-412 1965.

35. Joplin, G. F., Fraser, R., Hill, D. W., Oakley, N. W., Scott, D. J., and Doyle, F. H.: Pituitary ablation for diabetic retinopathy, *Quart. J. Med.* 34: 443-462 1965.

36. Pearson, O. H.: cited by Bradley, R. F. et al.: Pituitary ablation in treatment of diabetic retinopathy, *Med. Clinics N. Amer.* 49: 1105-1124 1965.

37. Sedan, R. and Harte, M.: Irradiation interstitielle hypophysaire dau le retinopathie diabetique, *Neurochirurgie* 12: 209-225 1966.

38. Ray, B. S.: cited by Bradley, R. F. et al.: Pituitary ablation in treatment of diabetic Retinopathy, *Med. Clinics N. Amer.* 49: 1105-1124 1965.

39. Sangalli, F.: Conference on diabetic retinopathy, *Survey of Ophthalmology* 6: 498-511 1961.

40. Lawrence, J. H., Tobias, C. A., Linfolt, J. A., Boni, J. L., Gottschalk, K. and Kling, R. P.: Heavy particles, the Bragg curve and suppression of pituitary function in diabetic retinopathy, *Diabetes* 12: 490-501 1963.

41. Oosterhuis, J. A., Loewer-Sieger, D. H., and van Gool, J.: Treatment of diabetic retinopathy by x-radiation of the pituitary, *Acta Ophthal.* 41: 621-639 1963.

42. Adams, D. A., Rand, R., Roth, N., Heuser, G., and Parker, M.: cryohypophysectomy in treatment of diabetic retinopathy, read before the Sixth Congress International Diabetic Federation, Stockholm, Sweden, July 30-August 4, 1967.

43. Bleasel, K., and Lazarus, L.: Cryogenic hypophysectomy, *Med. J. Australia* 52: 148-150 1965.

44. Conway, L. W., and Collins, W. F.: Cryohypophysectomy: technique, evaluation and results in twenty cases, read before the American Academy of Neurological Surgery, Cincinnati, Ohio, October 14, 1965.

45. Wilson, C. B., Winternitz, W. W., Bertan, V., and Sizemae, G.: Sterotaxic cyrosurgery of the pituitary gland in carcinoma of the breast and other disorders, *JAMA*, 198: 587-590 1966.

46. Zervas, N. T., Wesson, L. G., Soricelli, R. R., Rupp, J. R., and Field, R. A.: Radio-frequency hypophysectomy for diabetic retinopathy, read before Sixth Congress International Diabetic Federation, Stockholm, Sweden, July 30-August 4, 1967.

47. Goluboff, B., Shenkin, H. A., and Haft, H.: The effect of mannitol and urea on cerebral hemodynamics and cerebrospinal fluid pressure, *Neurology*, 14: 891-898 1964.

■ Drs. Shenkin, Gutterman and Fine-stone are associated with the department of neurosurgery and metabolic section of the department of medicine. Episcopal Hospital.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B — bacitracin — neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'[®]

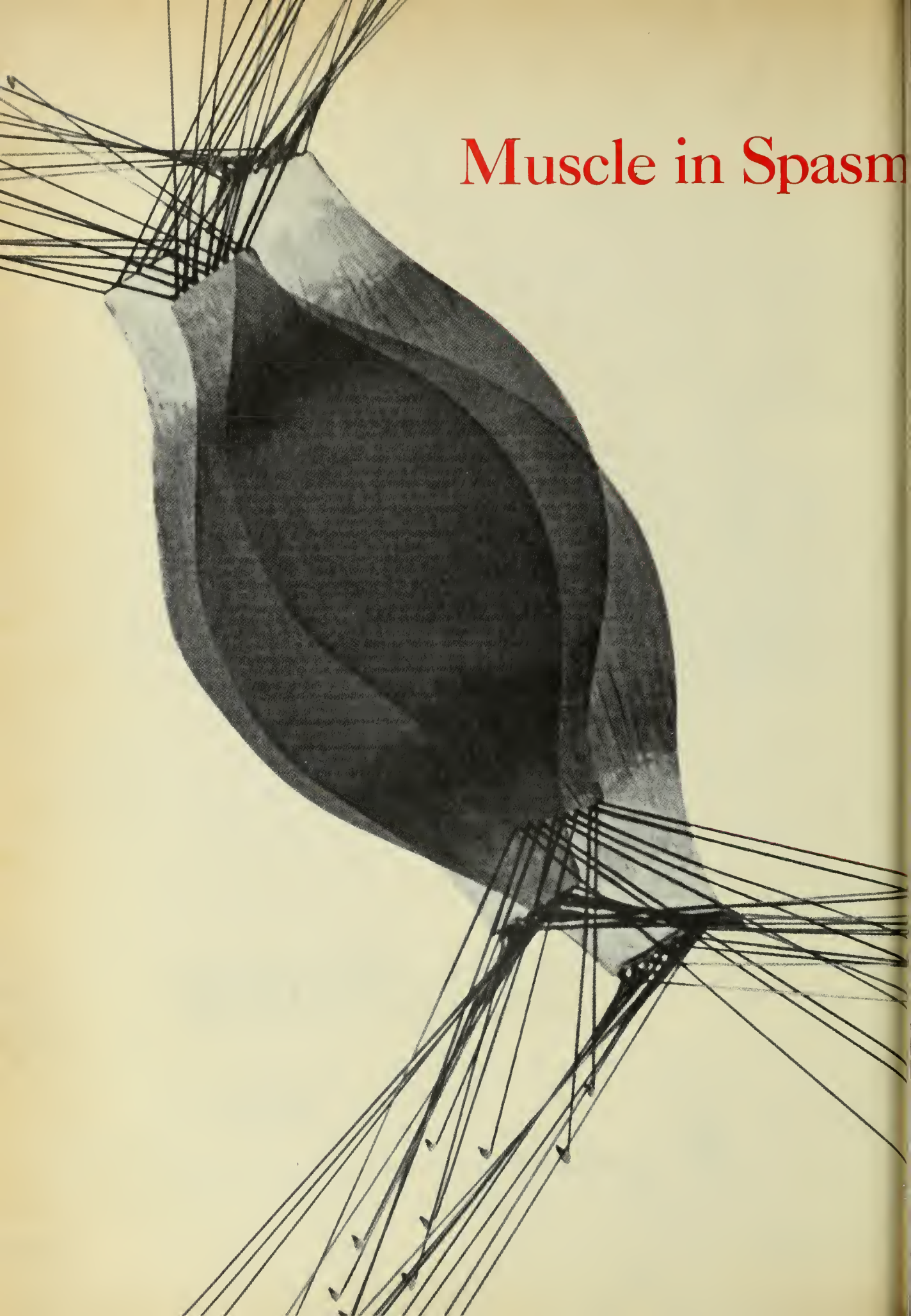
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Muscle in Spasm



and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium[®] (diazepam)
2-mg, 5-mg, 10-mg tablets





Louie!
You're
back.

Louie lost weeks with
a painful shoulder. That's a lot of fish.

It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

If it doesn't work in a week, forget it

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute counter-measures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should

be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (6) N 46-070-A

**For complete details,
please see full prescribing information.**



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsey, New York 10502

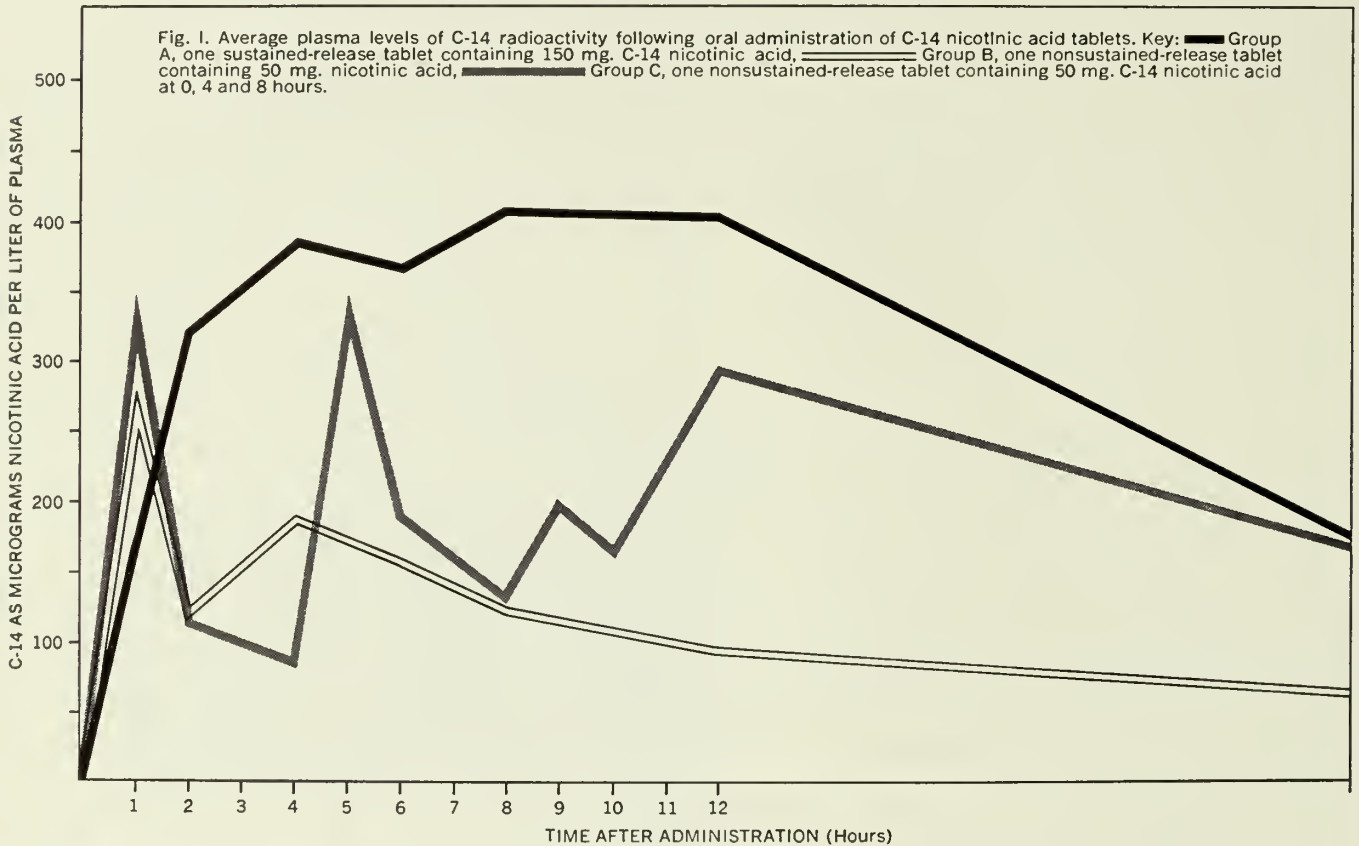
BU-5926

Butazolidin® alka Geigy

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Sustained circulatory, respiratory and cerebral stimulation for the



(fewer absent doses by
absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-

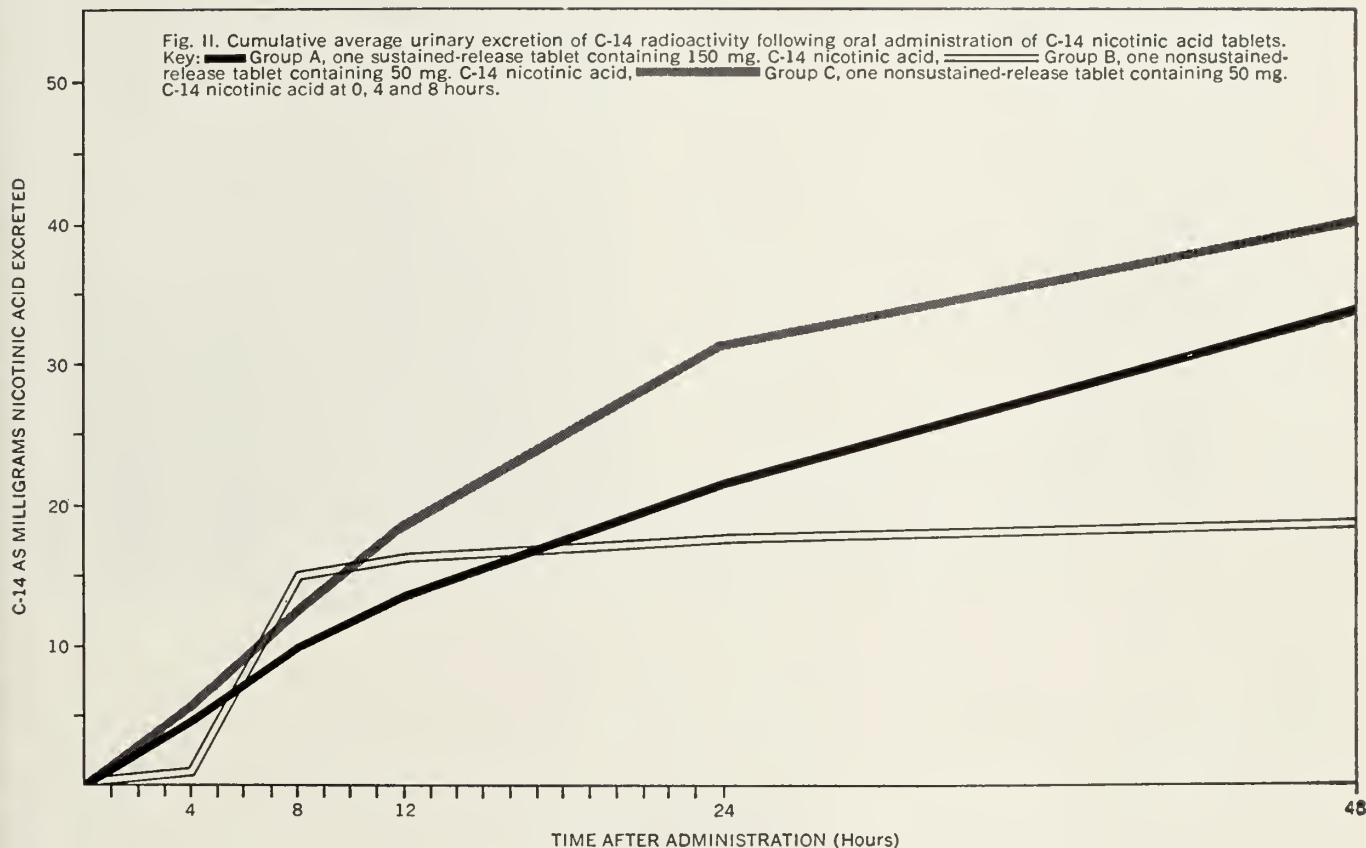
mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: — Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, — Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, — Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylentetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. 56:263 (Aug.) 1960. 3. Curran, T R., and Phelps, D. K.: Am. Pract. & Digest Treat. 11:617 (July) 1960.



"First with the Retro-Steroids"

PHILIPS ROXANE LABORATORIES

Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol[®] TT

nicotinic acid 150 mg., pentylentetrazol 300 mg.
Tempotrol[®] Time Controlled Tablet

*A double-blind study of the
use of indomethacin and placebo*



Fig. 1. Before treatment with Indocin.

Short Term Treatment of Acute Bursitis of the Shoulder

ABRAHAM COHEN, M.D.
RICHARD W. COHEN, M.D.
Philadelphia, Pennsylvania



Fig. 2. After 24 hours therapy with Indocin, 25 mgms every 6 hours around the clock.



Fig. 3. After treatment for one week with Indocin, 25 mgms every 6 hours around the clock.

About 80 to 90 percent of all cases of painful shoulder are due to subdeltoid or subacromial bursitis. The subdeltoid, subacromial or subcoracoid bursae are probably all one structure, partitioned by thin membranes. It is the largest of the approximately 140 bursae in the body. The subdeltoid is the one usually responsible for bursitis. Only rarely is there involvement of the bursa of the great trochanter.

A diagnosis of bursitis can be established only with difficulty. X-ray examination will confirm the diagnosis only if calcium is present.

It is necessary first to exclude certain traumatic lesions that may be mistaken for bursitis. Among these are sprains, dislocations, fractures and ruptured tendons. Another cause of painful shoulder that is frequently mistaken for bursitis is osteoarthritis. Osteoarthritis should be suspected especially in the presence of a history of chronic trauma to the shoulder. Arthritis of the shoulder without pain in other joints occurs only as osteoarthritis secondary to chronic trauma.

Certain types of employment produce localized overuse, or trauma, of

the shoulder. These include the work of the riveter, the carpenter and plumber; the policeman who continually raises and moves his arm to direct traffic; the fireman who must drag heavy hoses; and the baseball player. Occasionally, too, musicians, such as violinists and accordionists, suffer painful shoulder due to the constant strain produced by the position of the arm when they play.

Therefore, a history of habitual stress to the shoulder in a patient with pain in that region may point to osteoarthritis. At least, this is the likely diagnosis, particularly in patients whose work raises this suspicion. X-ray examinations will often confirm the diagnosis by revealing osteoarthritis of the acromioclavicular joint or of the shoulder joint itself. This condition, however, is often mistaken for bursitis.

The term, "subdeltoid bursitis," has been a cause of some confusion, for it has not been limited to lesions of this bursa. It apparently has come to mean any of a number of lesions that cause painful shoulder, including such disorders as calcification of the supraspinatus tendon or damage to the

musculotendinous cuff. Consequently, painful shoulder is generally attributed to either bursitis or tendinitis.

Signs and Symptoms

Of course, pain is the significant symptom of bursitis. Sudden onset of excruciating pain, radiating from the shoulder to the arm and into the fingers, is characteristic of acute bursitis. The pain is worse at night and is aggravated by movement. In addition, there is tenderness over the deltoid muscle or in the region of the tuberosity of the humerus or in the bicipital groove. X-ray examination may or may not show areas of calcification. Acute bursitis is relatively uncommon. Usually, the form of the disease seen by the clinician is chronic bursitis or an exacerbation of it.

Chronic bursitis may be a sequel to acute bursitis but more often begins as a chronic disease. The pain in the shoulder may awaken the patient in the early morning and, like acute bursitis, may be a sharp pain but is more likely to be a dull ache. It may radiate like the pain of acute bursitis to the side of the neck and down the arm and even into the

chest. It can be intermittent, depending on movement of the shoulder, or continuous. Movement is sometimes limited, from 25 to 100 percent, or there may be no limitation.

X-ray examination is not of much value in establishing the origin of the pain. Even if there is evidence of calcification, the amount of calcium is likely to be far out of proportion to the intensity of pain. Symptom-free calcified bursitis has been revealed by routine x-rays of the shoulders. A negative x-ray therefore has little significance.

Treatment

Indomethacin therapy of bursitis has been reported in a few studies,^{1, 2} but these were largely concerned with other musculoskeletal disorders. Jacobs² compared the drug with placebo in sixty patients characterized as having painful stiff shoulder and found indomethacin produced superior benefits. One of the present authors has reported his experience with indomethacin in treating rheumatoid arthritis.³ The results of that study generally confirmed the findings of other physicians that the drug is a valuable adjunct to steroid therapy for this disease. Consequently, it was deemed worthy of a trial in treatment of bursitis.

Controlled studies have shown that the drug is an effective analgesic agent, free of the characteristic liabilities of hormonal treatment. As for the side effects associated with the drug, the principal problem appears to be gastrointestinal irritation. This has not usually been excessive, however. Laboratory findings have been mostly normal, except for occasional positive guaiac tests for occult blood and occasional decreases in hemoglobin and hematocrit levels. Studies with radioactive chromate-tagged red blood cells indicate that large doses of indomethacin (50 mg. four times a day) produce less fecal blood loss than average doses of aspirin (600 mg. four times a day).⁴

The obvious advantage of non-steroid anti-inflammatory agents is the possibility they offer of reducing or eliminating steroids in the treatment of the chronic rheumatic diseases. In an unpublished study done by the authors on the treatment of rheumatoid arthritis with a combination of indomethacin and steroids, it was possible to eliminate steroids completely in 25 percent of the cases and to maintain improvement on indomethacin alone.

One of the lessons learned with the use of steroids is also applicable to indomethacin. It was found that an optimal dosage was a function not only of the amount of drug but also of strict regimen. If the lowest possible therapeutic dose is to be used, it is essential that the drug be administered regularly around the clock. A schedule of medication four times a day, for example, is often interpreted as one dose with each meal and before going to bed. Such a schedule will be inadequate to maintain a continuous blood level. Or the suffering patient is likely to retire early and consequently is without medication for nine or ten hours or longer. During this period, the amount of the drug in the body falls below the minimum required for beneficial effect. An optimal dose, therefore, depends on strict adherence to the regimen of administration. The apparent relationship between round-the-clock administration of a drug and its improved effectiveness was observed by the senior author with other anti-inflammatory agents. Admittedly, this observation has not been demonstrated in controlled studies of dosage schedules. The different clinical results, however, after establishing a full 24-hour regimen in place of a previously unsatisfactory daytime schedule, have been persuasive. This experience led to the same regimen for indomethacin in this study.

Methods and Materials

Patients with acute bursitis or an acute exacerbation of chronic bursitis of the shoulder who appeared at the arthritis clinics with which the authors are associated were selected. Thirty-seven men and women started on the trial medication; one did not return after the initial visit, leaving thirty-six who completed the week's trial. Thirty-one were men, and five were women. Their ages ranged from twenty-five to eighty-two. Patients were excluded if they were younger than twelve years. Also excluded were women of child-bearing age, unless they were on contraceptive measures or not exposed to conception. Other grounds for exclusion were: gastrointestinal disease (esophagitis, gastritis and ulcers), because of the potential irritant properties of oral indomethacin; liver disease; a history of headaches; unreliable or unstable persons because this type might distort subjective symptoms by either magnifying them or stoically minimizing

them; other connective tissue disease (scleroderma, dermatomyositis and rheumatoid arthritis); and known hematologic disorders.

An evaluation of the severity of the attack of bursitis was made for each patient before treatment and daily for the first three days of treatment. Cases were classified as *moderate*, *severe*, and *very severe*. Mild cases were not included, because their response to therapy has been found to be variable, and the rate of response cannot be evaluated in statistical terms. The number of patients in each classification according to severity was as follows: *Moderate bursitis*: eighteen; *severe bursitis*: thirteen; *very severe bursitis*: five.

The severity was determined on the basis of the amount of pain, tenderness and limitation of motion in each case. Each of these parameters was graded, as follows:

Pain: *Very Mild*—A dull ache, usually not constant and not very bothersome. The patient can sleep. *Mild*—A dull ache, usually continuous. Movement is uncomfortable. *Moderate*—An annoying ache, steady or intermittent and worse with movement. *Severe*—Usually a steady and incapacitating pain. Any movement causes pain. Patient cannot sleep. *Very severe*—A constant and excruciating pain, usually throbbing. The patient is generally miserable and cannot sleep.

These classifications were numerically graded, from 1 (*Very Mild*) to 5 (*Very Severe*). At each visit of the patient, the intensity of his pain was recorded on this scale.

The same scale was used to measure the tenderness of the shoulder and the limitation of movement. The grades of tenderness were evaluated as follows:

Tenderness: *Very Mild*—Hard pressure produces little pain. *Mild*—Hard or firm pressure produces some pain; gentle pressure produces none. *Moderate*—Gentle pressure produces a little pain and hard pressure, considerable pain. *Severe*—Gentle pressure produces acute pain. *Very Severe*—Touching causes much pain. Patient cannot bear any pressure on the area.

Limitation of motion was measured by both active movement (the patient moves his shoulder until he stops because of pain) and passive movement (the examiner slowly moves the shoulder to the point of pain). A percent of limitation was then deter-

mined and was converted to a grade, as follows:

- 0- 20% restriction = grade 1.
- 20- 40% restriction = grade 2.
- 40- 60% restriction = grade 3.
- 60- 80% restriction = grade 4.
- 80-100% restriction = grade 5.

Limitation of motion was also recorded photographically (see pictures). This method has been developed by one of the authors⁵ to obtain a graphic quantitative measurement of immobility in affected arms before and after therapy. As can be seen in the photographs reproduced here, the patient is simply posed before a semi-circular chart marked with clock-like divisions. He is then told to raise the affected arm to the point of pain and, in so doing, aligns it with one of the numbered divisions on the chart. Any subsequent change in range of movement is thus demonstrable in terms of these fixed measures.

Those patients admitted to the study were given a bottle of capsules, containing either indomethacin or a placebo of inert ingredients (which consisted of lactose U.S.P., 258 mg., and magnesium stearate U.S.P., 2 mg.). The bottles were numbered in random order but not otherwise identified. The contents of each was known only to the manufacturer who supplied them, and the identity was made known to us only at the conclusion of the trial.

The patients were instructed to take a capsule every six hours around the clock. The indomethacin capsules contained 25 mg. of the drug, for a daily dosage of 100 mg. They were told that no other medication was to be taken during the week-long trial. Patients were told to return to the office on the following schedules: after twenty-four hours on the medication, after two days, three days and then seven days. At each visit, the severity of the patient's condition was evaluated and recorded, and the degree of pain, tenderness and limitation of movement were also graded.

Results

Complete data were collected on thirty-six patients. The results of treatment at each time of observation were graded and statistically evaluated, as shown in TABLE I.

At each day of observation, the nineteen patients who took indomethacin showed better response, on the average, than the seventeen patients who took placebo. The difference in

TABLE I

Response to Therapy		Days After Therapy							
		1		2		3		7	
		No. of Pts.		No. of Pts.		No. of Pts.		No. of Pts.	
	Numerical Grade	Indo.	Plac.	Indo.	Plac.	Indo.	Plac.	Indo.	Plac.
Worse	1	—	1	1	1	1	2	1	2
None	2	5	10	4	9	5	7	4	6
Fair	3	2	3	1	2	2	2	2	2
Good	4	8	3	5	3	3	5	3	6
Excellent	5	4	—	8	2	8	1	9	1
Total Patients		19	17	19	17	19	17	19	17
Mean Score		3.6*	2.5	3.8**	2.8	3.6†	2.8	3.8**	2.9

* Statistically significantly different from corresponding placebo value, $P < 0.01$

** Statistically significantly different from corresponding placebo value, $P < 0.05$

† Statistically significantly different from corresponding placebo value, $P < 0.10$

TABLE II
Severity of Pain Before and After Treatment (7 Days)

Severity		Indomethacin		Placebo	
		No. of Pts.		No. of Pts.	
		Before	After	Before	After
No Pain	0	0	10	0	3
Very Mild	1	4	3	1	6
Mild	2	2	2	4	2
Moderate	3	9	2	5	4
Severe	4	4	2	3	2
Very Severe	5	0	0	4	0

TABLE III
Tenderness Before and After Treatment (7 Days)

Severity		Indomethacin		Placebo	
		No. of Pts.		No. of Pts.	
		Before	After	Before	After
No Tenderness	0	1	10	1	3
Very Mild	1	4	4	1	6
Mild	2	4	2	4	2
Moderate	3	8	3	6	4
Severe	4	2	0	4	2
Very Severe	5	0	0	1	0

average scores is statistically significant at each time of observation, except on the third day after the start of treatment.

Nine patients who were diagnosed at the start of treatment as having severe bursitis received the active drug, and, after a week's therapy, four of them showed a Good or Excellent response, one showed Fair response, three showed No response, and one was Worse.

There were also nine patients in the placebo-treated group who were diagnosed as having severe bursitis, and, after a week's therapy, their responses were the same as in the drug-treated group, that is, four Good or Excellent, one Fair, three No response, and one Worse.

Moderate cases responded better to the drug than to the placebo. Ten patients who were diagnosed as having moderate bursitis were given indomethacin, and eight of them had Good or Excellent response, one had Fair response, and one No response. In the placebo-treated group, there were eight patients with moderate bursitis, and of these, three had a Good response, one had Fair response, and four had No response.

At the end of the week's trial, there were thirteen patients who were judged to have had no response to the capsules or who had become worse. Five of these were found to have received the drug, and eight had received the placebo. In other words, 26 percent of the patients who had taken indomethacin failed to benefit from it, and 47 percent of those who had taken placebo failed to benefit from that. Only one patient became worse while taking the drug; he is an

eighty-two-year-old man with recurrent severe bursitis.

A difference between the two therapies is also to be seen in a comparison of pain, tenderness and restricted motion before and after treatment.

The symptom changes after treatment were analyzed statistically, and it was found that after the first day of treatment pain relief with indomethacin was significantly superior to that with placebo ($P < 0.05$). The superiority of the drug in the relief of pain was statistically significant thereafter.

The relief of tenderness was significantly greater with indomethacin than with placebo ($P < 0.05$) after the second, third and seventh days of treatment.

Twelve patients who received indomethacin had some degree of limitation of their shoulder movement at the start of treatment (see TABLE IV). In eight of them, limitation was 50 percent or more. Five of the twelve regained full range of movement after a week. Three others gained a greater degree of movement than they had had before treatment but less than full range of movement. The remaining four patients with limited shoulder movement were not improved by the drug. (One patient who initially had no limitation of movement developed 20 percent limitation by the end of the study.)

All patients on placebo had limitation of shoulder movement at the start of treatment, and only two had complete freedom of movement after treatment. Five improved their range of movement, eight remained the same, and two were worse.

Photographs taken before and after treatment illustrate the dramatic improvement in shoulder movement that is seen in some patients after only one week.

Side Effects

One patient who received the drug and one who received placebo reported untoward reactions during treatment. The patient who received indomethacin, a forty-one-year-old man with severe bursitis, developed diarrhea in the middle of the week's trial, and it continued for two days and then ceased. The patient on placebo, a fifty-six-year-old man with severe bursitis, complained of nausea after two days of treatment. An antacid was prescribed, and the nausea ceased next day.

Summary

Thirty-six men and women with moderate to very severe bursitis of the shoulder were treated for one week with either indomethacin or placebo (25 mg. capsules q. 6h.) in a double-blind trial. Response of the nineteen patients who took indomethacin was Fair to Good (3.8 on a 5-point scale). Response of the seventeen who took placebo was None to Fair (2.9 on the scale). The difference in response between the two groups was statistically significant. Side effects occurred in two patients, viz., diarrhea of short duration in one who took indomethacin and nausea controlled with antacid in one who took placebo.

REFERENCES

1. Mezey, K. C.: Clinical evaluation of indomethacin, presented at the International Symposium on Non-steroidal Anti-inflammatory Agents, Freiburg, Germany, May 1966.
2. Jacobs, J. H.: A double-blind trial of the treatment of painful stiff shoulder with indomethacin, Proceedings, Symposium on Anti-inflammatory Drugs, pp. 85a-85i, Minerva Medica, Turin, Italy, 1965.
3. Cohen, A.: Indomethacin. Congress of Rheumatology, Piestany, Czechoslovakia, 1964.
4. Personal communication.
5. Cohen, A.

TABLE IV
Limitation of Motion Before and After Treatment (7 Days)

Severity	Grade	Indomethacin		Placebo	
		No. of Pts.		No. of Pts.	
		Before	After	Before	After
No Limitation		7	11	0	2
0-20%	1	3	4	5	7
21-40%	2	1	0	1	0
41-60%	3	7	3	5	6
61-80%	4	1	1	5	2
81-100%	5	0	0	1	0

■ Dr. Abraham Cohen is associated with the department of medicine, Jefferson Medical College. Dr. Richard Cohen is a resident in orthopaedic surgery, University of Pennsylvania Hospital. This paper was read in Prague, Czechoslovakia, on the occasion of the seventieth birthday of Professor Frantisek Lench, director of rheumatic diseases, Charles University.

Suicide With Amitriptyline-Perphenazine-Combination

CHARLES L. WINEK, Ph.D.
FRED W. FOCHTMAN, M.S.
WELLON D. COLLOM, M.S.
Pittsburgh, Pennsylvania

The combination of the antidepressant, amitriptyline, and the tranquilizer, perphenazine, has been used with success in the treatment of various psychiatric disorders. The combination is available commercially in various strengths under the names of Etrafon* and Triavil.**

A report by Loprete¹ summarized eight cases of Etrafon over-dosage either accidental or suicidal in nature. He reported death in two infants, but no deaths in adults. The highest amount ingested by an adult was 54 tablets representing 108 mg of perphenazine and 1.35 gm of amitriptyline. Bowes² reported that the combination of 25 mg amitriptyline and 2 mg of perphenazine has a lower toxicity than the combination at strengths of 25:4 and 10:4, the most toxic. One of his patients ingested 150 tablets of the 25:2 combination and recovered. He did not indicate the treatment used. Loprete, however, indicated the successful treatment in his patient that ingested thirty tablets of the 25:2 combination. None of the reports in the literature indicate that toxicological analyses were performed to determine blood levels of the two drugs.

A recent case of a successful suicide with Etrafon stimulated this report.

Case Report

A fifty-four year old, white female that had been separated from her husband had been received at this office after treatment in a hospital for overdosage of Etrafon. She was found in her bedroom by her sister in a comatose condition. She was admitted to the hospital at 9:50 p.m. and received gastric lavage, oxygen therapy and intravenous glucose. The pupils were equal and responded slowly to light. Blood pressure (B.P.) 85/60, pulse 90, respirations 20 per/min. She did not respond to Emivan† nor Levophed.‡ She died at 5.25 a.m. the next morning. No autopsy was performed. Toxicological analyses were

performed on blood and urine with the following levels obtained:

	Perphenazine	Amitriptyline
Blood	0.35 mg%	0.42 mg%
Urine	21.1 mg%	45.0 mg%

Analyses for other toxicants were negative. The patient had received a prescription the day before for 56 tablets of Etrafon. The empty prescription vial was found by her side.

Discussion

Despite the hospital treatment the patient still had a measurable level of both drugs in her blood. Curry³ reports that levels of phenothiazines in excess of 0.1 mg per 100 ml of blood indicate that large doses were ingested. A single dose of one gram of chlorpromazine, for example, will generally give a blood level of about 0.1-0.2 mg percent. Curry also indicates that a phenothiazine can be detected in a 10 ml sample of blood, more than a therapeutic dose has been ingested. Psychotic patients frequently receive high dosages of phenothiazine type drugs with no toxic effects.

In the case reported here, the patient ingested 112 mg of perphenazine, which represents a dose of about 2 mg/kg of her body weight. The acute oral LD₅₀ in rats is given as 318 mg/kg and greater than 100 mg/kg in dogs.⁴ It is interesting to note, that if one directly extrapolates from animal to man, the amount ingested is about 160 times less than the LD₅₀ dose for the rat and fifty times less than that of the dog.

The number of tablets ingested also represents 1.4 gm. of amitriptyline, which has a toxicity rating of 4, indicative of a very toxic substance.⁵ The acute oral LD₅₀ for amitriptyline is 4.64 mg/kg in female rats and 600 mg/kg in male rats.⁶ It appears from the toxicity data that amitriptyline is more toxic than perphenazine at least in the female species. The ingestion of 1,250 mg,⁷ 950 mg⁸ and 75 mg⁹ of amitriptyline has resulted in death. Discarded ingestions of as high as 1,875 mg¹⁰ of amitriptyline recovered following forced alkaline diuresis.

The most important consideration in assessing the lethality of a drug dosage form is the time factor involved between ingestion of the dosage form and treatment, if any.

Because of the six hours of hospital treatment, the levels that were obtained for perphenazine and amitriptyline were low. A better indication of overdosage is the level of phenothiazine in the liver. Curry³ indicates that the liver levels are generally higher than blood levels.

A report from the National Clearinghouse for Poison Control Centers¹¹ indicates that hemodialysis is of limited value in Etrafon ingestion. The life saving procedure that was reported was exchange transfusion using 50/50 fresh and bank blood. Steel *et al*¹² reported extensively on the clinical features and treatment of amitriptyline poisonings. This article should be consulted for the most effective life-saving procedures.

REFERENCES

1. Loprete, F. P.: Etrafon: a case report, *Penna. Medicine*, 70: 65-66, 1967.
2. Bowes, H. A.: Amitriptyline, perphenazine, and psychotherapy, *Psychosomatics*, 8: 1-3, 1967.
3. Curry, A. S.: *Poison Detection in Human Organs*, Charles C. Thomas, Springfield, Ill. 1963.
4. Gordon, M. and McCandles, R. F. J.: *Handbook of Toxicology Vol IV: Tranquilizers*, W. B. Saunders Co., Philadelphia, 1959.
5. Gleason, M. N., Gosselin, R. E., and Hodge, H. C.: *Clinical Toxicology of Commercial Products*, Second Edition. Williams & Wilkins Co., Baltimore, 1963.
6. Smith, R. T., Merck Sharpe & Dohme Research Laboratories, personal communication, 1967.
7. Sunshine, P. and Yaffe, S. J.: Amitriptyline poisoning: Clinical and pathological findings in a fatal case., *Am. J. Dis. Child.* 106: 501-506, 1963.
8. Davies, D. M. and Allaye, R.: Amitriptyline poisoning, *Lancet* 2: 543, 1963.
9. Fendrick, G. M.: Hazards to health: amitriptyline, *New England. J. Med.* 267: 1031-1032, 1962.
10. Ward, F. G. and Tin-Myint, B.: Amitriptyline poisoning, *Lancet* 2: 910, 1965.
11. National Clearinghouse for Poison Control Centers Bulletin. July-Aug., 1967.
12. Steel, C. M., O'Duffy, J., and Orown, S. S.: Clinical effects and treatment of imipramine and amitriptyline poisoning in children, *Brit. Med. J.* Sept. 1967, 663-667.

■ At the Allegheny County Coroner's Office, Dr. Winek is chief toxicologist, Mr. Fochtman is toxicologist and Mr. Collom is assistant chief toxicologist.

* Schering Corporation

** Merck, Sharp & Dohme

† USV Pharmaceutical Corp.

‡ Winthrop Laboratories



Future Trends in Stroke Management

*Some suggestions are offered to improve management
and to reverse the present trends*

LAWRENCE C. McHENRY, JR., M.D.
Philadelphia, Pennsylvania

The current management of stroke depends primarily on early and accurate diagnosis, and on treatment during the initial phase of the disease. At the present time in this country there exists considerable controversy concerning the treatment of stroke by anticoagulation, extracranial vascular surgery, or vasodilating drugs, and by the treatment of moderate hypertension. To facilitate early and accurate diagnosis of stroke and to improve the treatment of the patient, the following suggestions are put forth. Although these will not solve all the problems of stroke management, trends may be established that later will pay dividends.

Early Signs of Stroke

The early manifestations of cerebrovascular disease or stroke can be multitudinous, varying from acute catastrophic collapse to gradual mental or behavioral deterioration. There are, however, certain hallmarks of

cerebrovascular disease which are quite characteristic of the disorder. In the nationwide attack on cancer, the American Cancer Society has widely publicized the early manifestations of the disease. The broad publicity given to these clinical characteristics has helped in the early detection of this disease. It would seem worthwhile to give similar wide publicity to the primary manifestations of cerebrovascular disease. Since the effective treatment of stroke depends mostly on recognizing the disease in its early stages, the cardinal symptoms of stroke should likewise be broadly emphasized. This could be done through such organizations as the American Academy of Neurology or the Council on Cerebrovascular Disease of the American Heart Association. The American Heart Association and its various chapters have great capabilities in the dissemination of information.

It is suggested that the "seven danger signals of stroke" be publicized. In this way more patients with the early manifestations of the disease will be brought to the attention of their general physician and in turn to the neurologist or internist. Although the manifestations of circulatory disturbances in the distribution of the internal carotid artery and the basilar-vertebral system vary considerably and mimic other neurological conditions, there are certain symptoms which are prominent in cerebrovascular insufficiency. Seven cardinal manifestations of cerebrovascular disease are the abrupt onset of one or more of the following symptoms:

1. Weakness of the hand, arm, or leg on one or both sides of the body
2. Numbness of the face, arm, or leg on one or both sides of the body

3. Blurring of vision of one eye or to one side
4. Double vision
5. Severe dizziness or vertigo
6. Clumsiness or incoordination of one hand, or difficulty walking
7. Difficulty speaking, understanding, or reading.

Many other symptoms such as headache and sudden loss of consciousness may also be manifestations of cerebrovascular disease, but the above seven symptoms are the most important. It also must be pointed out that these may be symptoms of other neurological diseases, such as multiple sclerosis, but in individuals over forty-five years, transient cerebrovascular insufficiency must be given careful consideration.

The Stroke Care Unit

The second suggestion to improve the management of the patient with transient ischemic attacks or an acute stroke is the orientation of personnel, and the establishment of areas in large community hospitals for the care of stroke patients. During the last five to ten years, the utilization of Coronary Care Units with careful monitoring of cardiovascular functions has greatly diminished the mortality from cardiovascular disease. In a similar vein the establishment of the Stroke Care Unit could facilitate the treatment of the stroke patient.

At the present time there is no well-defined concept for the treatment and management of the patient with a stroke. The clinical manifestations may vary from complete motor paralysis and respiratory impairment to individuals that are ambulatory with minimal or no neurological deficit. Although there is a wide spectrum of neurological disturbances, definite plans should be developed for the care of the stroke patient depending on the severity of his deficit. The common denominator in all patients with stroke is some alteration in cerebral circulation or cardiovascular function. In the Stroke Care Unit physicians can be trained in the accurate diagnosis of stroke; nurses, physiotherapists, and other ancillary personnel can be oriented to the specific problems of stroke patients and their care. In the Stroke Care Unit of a large hospital, acutely ill patients can be carefully monitored in a manner similar to that in the Coronary Care Units. Twenty-four hour moni-

toring of blood pressure, pulse rate, respiration, and other parameters such as end-expiratory carbon dioxide tension may help detect pathophysiological changes that lead to cerebrovascular insufficiency. Likewise, studies such as measurements of cerebral blood flow and cardiac output can be performed at certain specific intervals. Nontraumatic methods for cerebral blood flow measurement, such as the Xenon inhalation method, are currently being evaluated as effective tools in studying changes in the cerebral circulation in an individual patient.

Such an intensive overall approach to the patient with stroke has not been taken before except in certain centers for cerebrovascular research. Usually the stroke patient has been relegated to the general medical ward and managed according to established tradition with whatever facilities may be available. The Stroke Care Unit would not only help in the management of the acute episode, but would be oriented towards rehabilitation so that the patient can be returned to his family and if possible to his job. Also, the Stroke Care Unit could serve as a focus for ancillary research conducted on cerebrovascular physiology and alterations in cerebral circulation and cardiovascular function that occur in cerebrovascular disease. All data obtained from the clinical and research studies of such units should be processed for computer storage, retrieval and analysis, as well as for immediate care of the patient.

Cooperation Between Stroke Centers

In the last five years approximately sixteen centers for research in cerebrovascular disease have been established by the U.S. Public Health Service in large university centers or hospitals throughout this country. Last year the first meeting of the directors of these centers was held. Such annual meetings on the advances in research in cerebrovascular disease and on specific work done in the individual centers must be continued. In addition, a medium of exchange of information between these centers and other individuals working in the field of stroke must be established. A proposal to establish a journal has been suggested by the Council on Cerebrovascular Disease of the American Heart Association. This journal would not only serve as a focus for clinical and research work in the field of cerebrovascular disease, but also as

a means of recording and reporting the activities underway in individual centers.

A standardized nomenclature of the clinical diagnosis for stroke patients, and of the pathological description of the brain and blood vessels in cerebrovascular disease should be established. Some steps have been taken toward such a classification. This classification, as well as a standard clinical protocol for the neurological and medical evaluation of the stroke patient, could be used throughout the country in all centers participating in cerebrovascular disease research. At the present time a variety of diagnostic tags are still given to individual stroke patients. The establishment of a specific disease nomenclature, similar to the American Heart Association's classification of heart disease, could be applied to cerebrovascular disease.

Summary

Three suggestions are put forth as possible future trends in the management of stroke. With the creation of the President's Commission on Heart Disease, Cancer, and Stroke and the development of Regional Medical Programs, new approaches will have to be taken to the study of cerebrovascular disease. The remarkable advances made in the diagnosis and treatment of cancer and heart disease in the last twenty years have completely outpaced the work done in stroke. New ideas, new avenues of approach, and continuous re-evaluation of progress will help to answer many of the questions on the etiology, pathogenesis, and treatment of stroke.



■ Dr. McHenry is director of the Stroke Research Center, Philadelphia General Hospital.



Muscular Overuse and Serum Creatine Phosphokinase (CPK)

JOHN H. ARNETT, M.D.
Philadelphia, Pennsylvania

Increased concentrations of the enzyme creatine phosphokinase (CPK) may occur in the serum in many morbid conditions, including preeminently certain forms of muscular dystrophy and recent myocardial infarction. Although this enzyme is highly specific for muscle tissue,¹ the

effects of muscular exertion upon its concentration in the serum are, as yet, but little understood. The observations herewith recorded are interpreted as indicating that spectacular increases in serum CPK values may be expected after unwonted stress of normal muscles.

A white male, age 18, 5 feet 8 inches (173 cms.) tall, weighing 161 lbs. (73.2K), presented at the student health service of Drexel Institute of Technology on December 2, 1966 complaining of stiffness, tenderness and pain in the muscles of his shoulders, arms and abdomen. (TABLE I). These symptoms began on November 30th, one day after participating in a fraternity pledging ordeal requiring him to perform "push-ups" and "sit-ups" for about one and one-half hours, until he was unable to continue such exercise further. Two days after this exercise he noticed that his urine had a cloudy and slightly brownish appearance. On analysis it gave a +3 reaction for protein and a + 4 reaction to orthotolidine ("hemastix").* Microscopic examination revealed five dark granular casts and three leukocytes per high power field, considerable brownish detritus but no erythrocytes. Serial urine specimens passed thereafter gave progressively weaker orthotolidine reactions until on December 5th the tests became consistently negative. On this date the CPK level was 695 units (normal: 0-12 units), the serum glutamic oxaloacetic transaminase (SGOT) 780 units (normal: 5-35 units). On December 9th the muscle stiffness, pain and tenderness were no longer present and the following serum values were obtained; SGOT: 54 units, urea nitrogen: 25 mgs. percent (normal 5-20 mgs. percent), creatinine 1.097 mgs. percent (normal: 0.7-4.0 mgs. percent) and the creatinine clearance was 121 mls. per min. (normal: 90-120 mls. per min.). He has remained in good health since, except for an attack of infectious mononucleosis.

On February 14th, five young men (TABLE I) presented at the Drexel health service with complaints similar to those of the patient discussed above due to similar over-use of muscles. On examination the affected muscles felt as firm as though in full contraction, and were tender to pressure. Muscular stiffness and accompanying disability had gradually increased after the over-use of the muscles reaching its maximum in from two and one-half to four days, at which

* The laboratory was unable, because of the meager amount of pigment present, to determine whether this reaction was due to hemoglobin or myoglobin.

High CPK values frequently follow muscular overexertion

time the arms could hardly be raised to a horizontal position. Gradually the symptoms, disability and urinary changes disappeared. Complete recovery occurred in all cases in a month's time, though one student, even then, could not perform more than two "push-ups."

Discussion

Discoloration of the urine and muscular stiffness have often been observed after the over-use of muscles. To the urinary changes the term "march hemoglobinuria" has in the past usually applied. That this term is probably a misnomer may be inferred from the report of Remmers and Kaljot ² which showed that the pigment in the urine of eighteen recruits who had performed strenuous and prolonged exercise was not hemoglobin but myoglobin.

Our observations throw considerable light on the heretofore poorly understood relationship of CPK elevations in the serum to exercise. It appears from the literature ^{3, 4, 5} that the physiologic use of normal properly conditioned muscles does not lead to grossly elevated CPK and SGOT figures, but that the elevations reported here and by Remmers and Kaljot ² and others ^{6, 7, 8, 9}, probably indicate muscle damage. Examination of the muscles of rats subjected to over-use have shown areas of necrosis.¹⁰ Likewise, muscle biopsies on horses suffering from "Monday morning disease" or "Kreutzschlag," a myositis with myoglobinuria which occurs when the animals are exercised after a period of rest, shows similar changes

accompanied by CPK elevations.¹¹ The facts that the intravenous injection of myoglobin by Perri and Gorini ¹² into rabbits whose urine was acid caused renal failure, and that patients with myoglobinuria frequently manifest acute renal failure ¹³ indicate that the urinary changes described by Arnett and Gardner ¹⁴ after over-use of muscles are probably likewise due to the nephrotoxic effects of myoglobin which has been released into the circulation incident to the destruction of muscle tissue.

Conclusions

High serum CPK values are frequently found after unwonted physical exertion. It seems probable that the urinary changes often accompanying over-use of muscles are due to the release of myoglobin into the circulation incident to muscle damage.

Summary

Six cases of stiffness and induration of over-used muscles accompanied by urinary abnormalities and spectacular CPK elevations are reported. It is inferred from the literature that the moderate use of normal well-conditioned muscles does not result in significant CPK elevations. It is postulated that the abnormalities here reported are due to muscle damage, since no muscle dystrophy was known to exist in any of the six individuals or their families. It is suggested that the urinary abnormalities accompanying "march" myoglobinuria are due to the toxic effects of myoglobin upon the kidney.

TABLE I
Creatin Phosphokinase (CPK) Determinations and Urinalyses
After Over-Use of Muscles

Case	Age	Days After Exercise	Degree of Protein-Uria	Urine Result of Orthotolidine Test	Serum CPK Units Ater Over-Use of Muscles	One Month Later
# 1	18	2½	+3	+4	695	—
# 2	19	3	+1	+3	530	0
# 3	19	2	+1	0	332	8
# 4	19	3	+2	+4	610	0
# 5	19	3	+1	+3	400	8
# 6	21	4	0	0	344	5

REFERENCES

1. Hess, J. W., MacDonald, R. P., Frederick, R. J., Jones, R. N., Neely, J., and Gross, D.: Serum creatin phosphokinase (CPK) activity in disorders of heart and skeletal muscle, *Ann. Int. Med.* **61**: 1015-28 (Dec) 1964.
2. Remmers, A. R., Jr., and Kaljot, V.: Serum transaminase levels. Effect of strenuous and prolonged physical exercise on healthy young subjects, *JAMA* **185**: 968-70 (Sept. 21) 1963.
3. Pearce, J. M. S., Pennington, R. J., and Walton, J. N.: Serum enzyme studies in muscle diseases, Part 1. Variations in serum creatine kinase activity in normal individuals, *J. Neurol. Neurosurg. and Psych.* **27**: 1-4, 1964.
4. Pearce, J.: Serum creatine kinase and exercise, *Brit. Med. J.* **11**: 167, 1965.
5. Swaiman, K. F., and Awad, E. A.: Creatine phosphokinase and other serum enzyme activity after controlled exercise, *Neurology*, **14**: 977-80, 1964.
6. Ahlborg, B., and Brohult, J.: Metabolic changes after exercise, *Lancet* **I**: 1272, 1966.
7. Griffiths, P. D.: Serum levels of ATP: creatine phosphotransferase (creatine kinase). The normal range and effect of muscular activity, *Clin. Chim. Acta.* **13**: 413-20 (Apr.) 1966.
8. Schneider, K. W., and Heise, E. R.: Die Diagnostische Bedeutung einer erhöhten Kreatin-Phosphokinase Aktivität im Serum. *Deutsch. Med. Wschr.*, **88**: 520-25 (Mar. 15) 1963.
9. Vejjajiva, A., and Teasdale, G.M.: Serum creatine kinase and physical exercise, *Brit. Med. J.* **I**: 1653-4, 1965.
10. Altland, P. D., and Highman, B.: Effects of exercise on serum enzyme values and tissues in rats, *Amer. J. Physiol.* **201**: 393-5, 1961.
11. Gerher, H.: Aktivitätsbestimmungen von Serumenzymen in der Veterinarmedizin, *Schweizer Arch. für Tierheilk.* **107**: 685-697, 1965.
12. Perri, G. C. and Gorini, P.: Uraemia in the rabbit after injection of crystalline myoglobin, *Brit. J. Exper. Path.* **33**: 440-4, 1952.
13. Horowitz, H. I., and Jamshid, J.: Myoglobinuria after acute arterial occlusion, *New England J. Med.* **262**: 1116-19, 1960.
14. Arnett, J. H., and Gardner, K. D.: Urinary abnormalities from over-use of muscles, *Amer. J. Med. Sci.* **241**: 55-8 (Jan.) 1961.



■ Dr. Arnett is director of the Student Health Service, Drexel Institute of Technology.

Errant currents from faulty electronic equipment are reported imperiling patients in certain cases

A seemingly harmless voltage of 20 millivolts can kill a hospital patient under certain conditions. Moreover such a current may be generated by poorly designed electronic equipment.

Add to that the fact that there are today no Federal, state or local standards to regulate the design, construction and electrical safety of equipment used in a hospital room or doctor's office, and the potential for continuing tragedy exists.

This is the picture painted by medical and engineering critics of some of today's electronic equipment. Deaths have, in fact, already resulted, they say. The cause may be attributed on the death certificate to "ventricular fibrillation" or some comparable medical term.

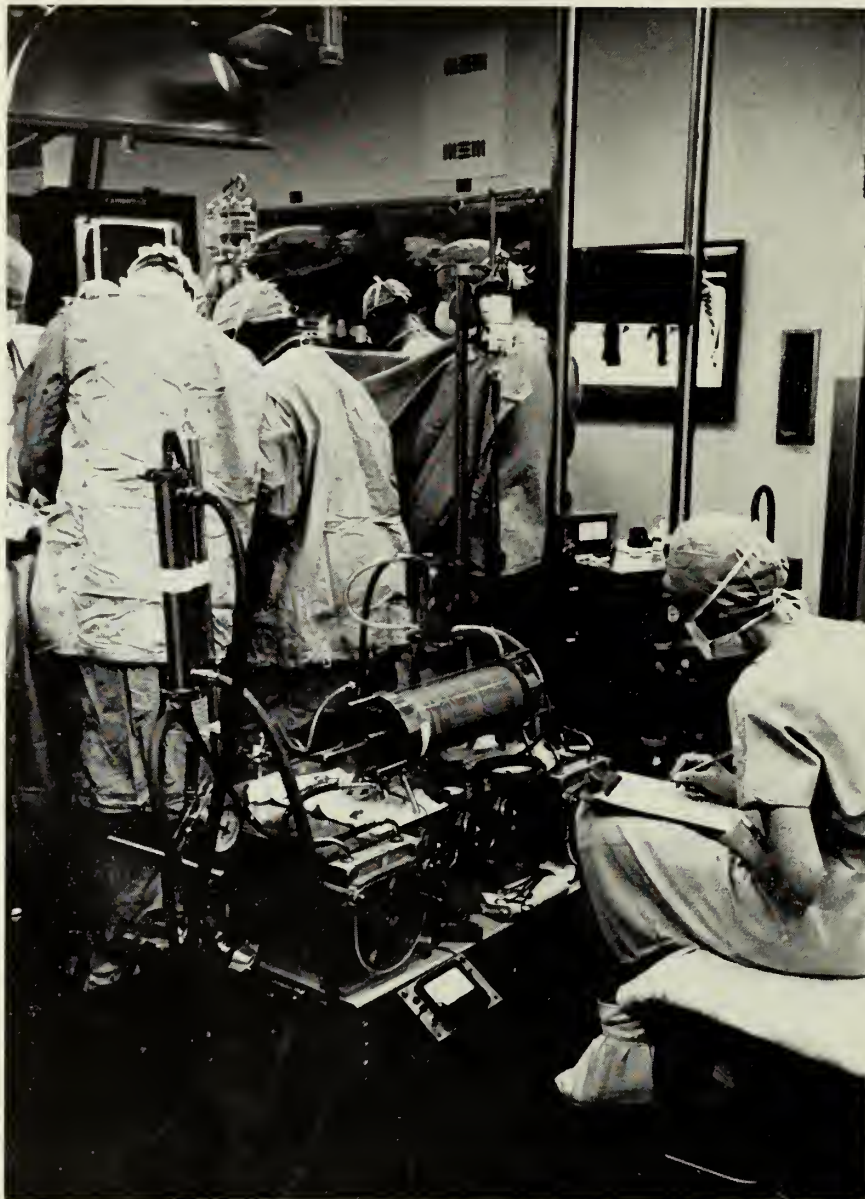
Two major flaws in equipment are turning up, according to the critics, as medical electronics, still in its infancy, reaches out toward growing markets:

- Faulty components in instrumentation and monitoring devices.
- Wiring systems that do not provide maximum protection for a patient.

Efforts to set safety design standards are being pressed by such professional groups as the Safety Committee of the Instrument Society of America, the Corresponding Committee of the IEEE and the Standards Committee of the Association for the Advancement of Medical Instrumentation. However, they report little headway toward achieving their goals. To fill the void, some manufacturers have begun to set their own standards. And in Congress a bill has been introduced in the House of Representatives to create a national commission that would study the quality controls and manufacturing procedures of, among others, companies that make medical instrumentation equipment.

Basic to the problem, the critics say, is that many hospitals lack adequate grounding systems for their electrical wiring. Except for their use in operating rooms, isolation transformers, designed to protect a patient from grounding accidents, are reported in scarce supply. Some hospitals do not use ground wires but rely on the conduit alone for grounding.

A leading critic, Dr. Paul Stanley,



The Tiny Flaws In Medical Design Can Kill

RONALD GECHMAN West Coast Editor

Reprinted from ELECTRONIC DESIGN, September 1, 1967.

professor of aeronautics, astronautics and engineering sciences at Purdue University, Lafayette, Indiana, says that doctors are well aware that small electric currents applied to the body can be fatal, but that they are not fully aware that malfunctioning hospital instruments can produce these voltages. The malfunction may be no more than a leaky capacitor in the instrument's power supply, and it may go unnoticed for some time, Dr. Stanley says.

A number of studies indicate that ventricular fibrillation is responsible for the majority of deaths from electrical shock, he reports. In ventricular fibrillation various groups of the heart muscle fibers stop operating in rhythm; instead they operate independent of one another. The result is weak, sporadic heart action that produces death.

Accurate figures on deaths occurring from accidental shocks in hospitals are nearly impossible to obtain, Dr. Stanley concedes. However, instances of death or near-death are reported from time to time.

At one midwest hospital, according to Dr. Stanley, forty to fifty patients were shocked over a few months in 1965, owing to a design error in an electromechanical dye injector. He declines to identify the hospital publicly, but he says the machine has since been removed from the market. Parts of it were anodized before assembly, and while this effectively insulated the parts and caused a high resistance path to the ground, the patients were grounded through other instruments. Since the patients were a better ground than the dye injector, current from the injector through the patients produced severe shock.

Similar cases were reported that same year by the University of Wisconsin. One patient died and six others were severely shocked by the same dye injector.

In Europe the leading British medical journal, *The Lancet*, reported two instances where patients were severely shocked by broken ground connections. Another case was reported last January in a news story from Yugoslavia telling of a patient's death from electrical shock caused by a defective electrocardiograph.

It is bad enough when a healthy person is subjected to such shocks, Dr. Stanley says, but the problem is drastically compounded when a hospital patient, especially one suffering from a heart problem, receives the

shock from an electrical device attached to his body.

In an ordinary, nonmedical situation, the resistance of two electrodes placed on the skin can vary from 500 ohms to 5K Ω , depending upon moisture, oils in the skin and the amount of dead skin under the electrodes. But needle electrodes inserted in to the body of a patient often reduce the body resistance to zero.

"Under these circumstances, a current as low as 20 μ A will probably cause fibrillation," according to Dr. Stanley. He adds that a voltage as low as 20 mV can be fatal and that a voltage of even 2 mV can be seriously harmful.

Assailing "poorly designed and shoddily built" equipment, Dr. Stanley says: "In some instances, circuits have been lifted directly from published articles on the design of medical instruments, without verifying the circuit's adequacy for the company's

particular application."

One example of a design error in a heart-lung machine, he says, was one in which the manufacturer put the fuses for six critical motors inside the machine; it took fifteen minutes to remove enough screws to reach the fuse box. The manufacturer subsequently relocated the fuses to a more convenient spot.

Other examples of poor equipment design cited by Dr. Stanley include these:

- Defibrillators that produced excessive shock energies.
- Equipment with chattering relays that produced high-voltage leakage currents.
- Pacemakers that were sensitive to pulses on the power line.

An instance where a cardiogram was being taken illustrates what can happen from faulty wiring, Dr. Stanley says. The technician received a

How Faulty Design Can Hurt

Errors in hospital equipment design may not impair the operation of equipment, but it may cause an electric current that exceeds the maximum safe limits to flow through a patient. The following examples illustrate two possible situations:

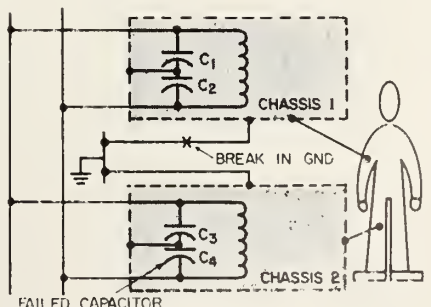
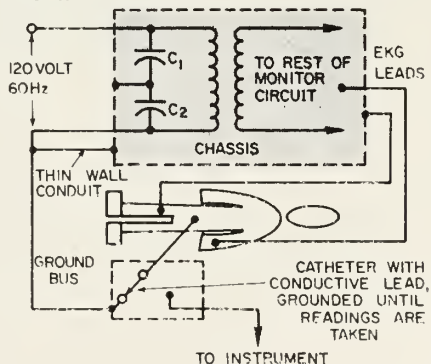
Figure 1 shows the circuit connection for a cardiac monitor attached to a patient undergoing a cardiac catheterization (insertion of a catheter into the heart).

If an isolation transformer is not used in the ac supply line and a leak occurs in C_1 of 100 mA, no noticeable impairment in the operation of the equipment will occur. However, the leak will cause current to flow from C_1 to ground through the conduit, often used as the ground system. Such a situation is possible and could cause as much as 65 mV, thirty times the safe value, to be placed across the patient's ventricular wall, which separates the chambers of the heart.

If two such failures should occur at the same time, even with the use of an isolated supply line, a dangerous shock hazard will develop. Figure 2 shows two instruments plugged into the same isolated ac line. The patient is connected to both chassis grounds. If a ground should open in one of the cords coupled with a defective capacitor, such as a leak in C_4 , a current

of nearly 20 mA, a possibly fatal amount, would flow through the patient.

Neither the open ground nor the leaky capacitor may be detected in the normal operation of the equipment.



severe shock every time she attempted to attach the leads to the patient. The problem was traced to a bed lamp frame that was shorted to its frayed ac line cord. The lamp was touching the bed frame and so was the patient's arm. Since the cardiogram was grounded through a three-prong plug and the lamp was not, the full ac line voltage, 117 volts, was shooting through both the patient and technician.

To prevent similar situations from arising, Dr. Stanley suggests that all supplies be connected through isolation transformers with a separate ground for each room. The transformer would prevent a shock from accidental grounding.

Dr. Jerome Silver, a former electrical engineer and now a surgeon at the Weiss Memorial Hospital in Chicago, echoes Dr. Stanley's concern over hospital safety. He was instrumental in forming rules for the hospital that require every electrical item to be equipped with a three-prong plug, and the plug must be installed by the hospital staff.

In addition Dr. Stanley suggests that all hospitals employ an engineer, who will be responsible for all their electrical systems and equipment. The engineer's duties, he says, should include:

- Inspecting all plugs on a periodic basis, to make sure they are in proper working order.
- Replacing tubes in the electronic equipment at recommended intervals, to minimize equipment failure at critical times.
- Checking instruments at recommended intervals, to ensure that they are properly calibrated.

One complaint hospitals have is that some manufacturers are unwilling to supply sufficient information for independent repair of defective instruments, because they receive extra revenue from the repair of their own equipment. When defective equipment is too large to be sent back to the company for repair, the hospital typically must pay \$150 a day for the company to send out an engineer to repair it.

Dr. Leon Riebmen, president of American Electronics Laboratories of Colmar, Pa., notes a problem that manufacturers face in designing medical equipment. "Many doctors and hospitals," he says, "cannot agree among themselves on an acceptable design approach for a new medical instrument. This disagreement has

caused so much confusion among the companies trying to develop new instruments that the companies are not apt to spend their funds for new instrument designs which could be used more profitably in other areas."

David Kilpatrick, head of American Electronic's Medical Engineering Division, says that because of the lack of general standards, the company has developed its own for medical equipment.

Among the company's rules for its designers are these:

- All equipment must have three-wire, color-coded cords and plugs.
- The hot side of the line must be fused no more than 200 percent of design current.
- Power switches must be installed on the hot side of the line or both sides, but never on the neutral side only.
- Modular combination of subsystems on a single patient must be made through a junction box that contains ground current monitoring, alarm and disconnect circuitry.

For wiring in hospital rooms, Dr. Stanley recommends that every electrical outlet have a No. 10 or No. 8 ground wire going to a ground bus. Each bus should handle a group of rooms and have a No. 0 wire going to a separate earth ground, he says. He also recommends that isolation transformers be used through the hospital.

Another recommendation of his is the use of a device to detect and sound an alarm automatically if an open ground connection occurs in a piece of operating equipment. The National Electric Code requires that such an alarm be installed in operating rooms, but it is not required elsewhere in the hospital.

Under the bill introduced in the House of Representatives last February by Rep. Ed. Reinecke (R-Calif.) a National Devices Standards Commission would be set up. The commission would not only study the instrumentation equipment used in hospitals and doctors' offices, it would also determine what Federal regulation of the equipment was needed to ensure that it meets minimum performance standards. The regulations would come under the jurisdiction of the Food and Drug Administration. Rep. Reinecke's bill, H.R. 6165, is under study.

At present the danger of shock from electrical equipment attached to a per-

son is not limited to hospitals and doctor's offices. It would extend to test equipment used in schools. One example brought to light recently involved a three-year study completed by the University of North Carolina for the Public Health Service.

The study was designed primarily to obtain information on the calibration and general operating condition of audiometers. It uncovered disturbing information about the safety of the machines. More than 25 percent of them were found dangerous to operate. Two of the 100 machines tested had a potential of 117 volts on the outside case when plugged into the ac line, and 25 more units tested had enough potential on the case to produce a shock when touched. In addition not a single machine tested met the study's calibration specifications.

Dr. Joseph Stewart, audiology consultant for the study, says that an audiometer that is out of calibration can cause serious errors in large-scale screening programs.

"It can, for example, miss the child with a potentially dangerous infection of the middle ear."

The audiometers tested were obtained from health departments, public schools, physicians and hospitals, military and industrial installations, the Veteran's Administration and hearing-aid dealers.

The study traced the inaccuracy of most test instruments to owners or operators who apparently had been unaware of the need for periodic calibration. Nearly half of the instruments had not been calibrated from the day they were purchased.

When technicians removed the back of one audiometer being used by a physician, they found a rat's nest inside, constructed in part from bits of the instrument's wiring and insulation materials.

Most manufacturers, the study found, were not utilizing the latest electronic techniques, such as solid-state construction. Kilpatrick says that some audiometers on the market today are at least thirty years behind modern technology.

One of the audiometers tested was a brand new unit. When it was removed from its packing case, it was found to be so badly out of calibration that it had to be torn apart and completely rebuilt.



Let's be specific about Campbell's Soups... and reducing diets

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101



THE RESTLESS DUODENUM...



DUODENUM—(Conventional X-ray) The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive. Is this duodenum normal?

Pro-Banthine® brand of propantheline bromide

For fifteen years Pro-Banthine has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthine has reestablished its pharmacologic effectiveness in facilitating diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

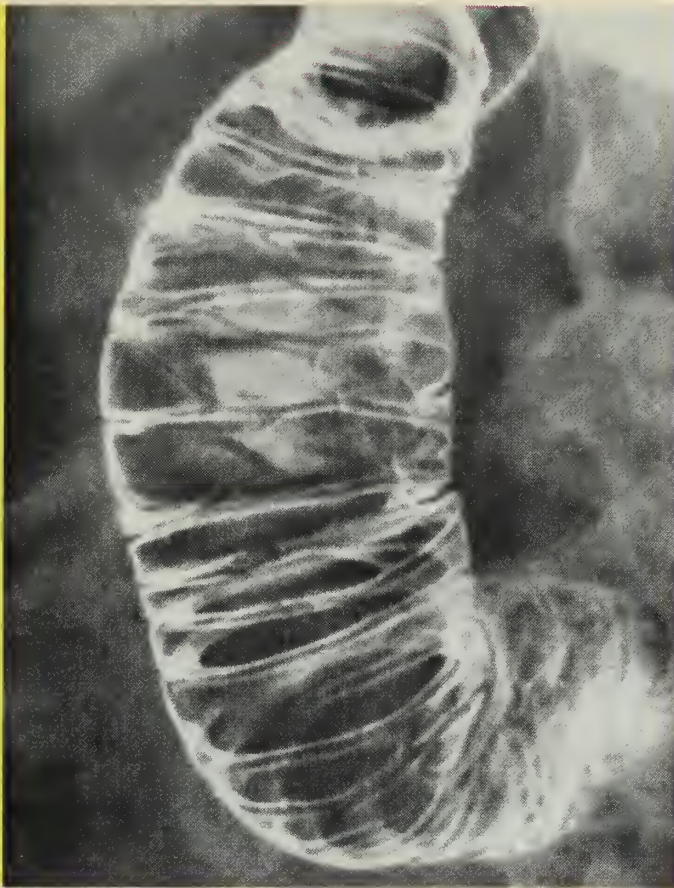
How the X-rays were taken

In the hypotonic duodenograph^{1,2} repro-

duced above, the gastrointestinal tract was relaxed with Pro-Banthine. The duodenum was intubated. Pro-Banthine in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis, and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

...AT REST



SAME DUODENUM—(Hypotonic X-ray) Pro-Banthine-induced duodenal calm permits full anatomic appraisal in the same patient. Duodenal normality is now evident.

calms the gastrointestinal tract

Contraindications: Glaucoma; severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand

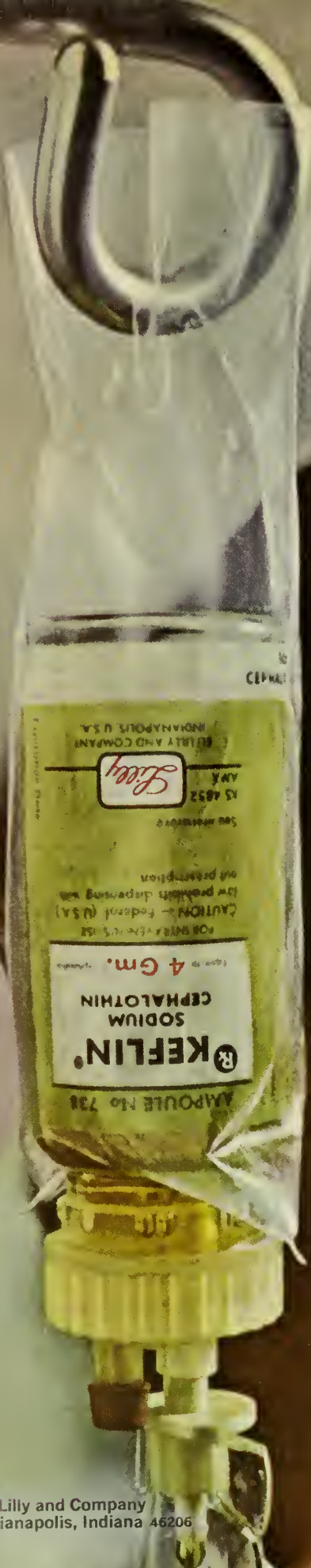
of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, *Radiology* 89:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique, *Lyon chir.* 50:445-460 (May-June) 1955.

SEARLE Research in the Service of Medicine



on call...

Keflin[®]
Sodium
Cephalothin

AMPOULE No. 738
® KEFLIN[®]
SODIUM
CEPHALOTHIN
4 Gm.
CAUTION - Federal (USA)
low probability dispersing with
out prescription
See monograph
Eli Lilly and Company
Indianapolis, U.S.A.



Eli Lilly and Company
Indianapolis, Indiana 46206

800186

the spasm
reactors
in your practice
deserve



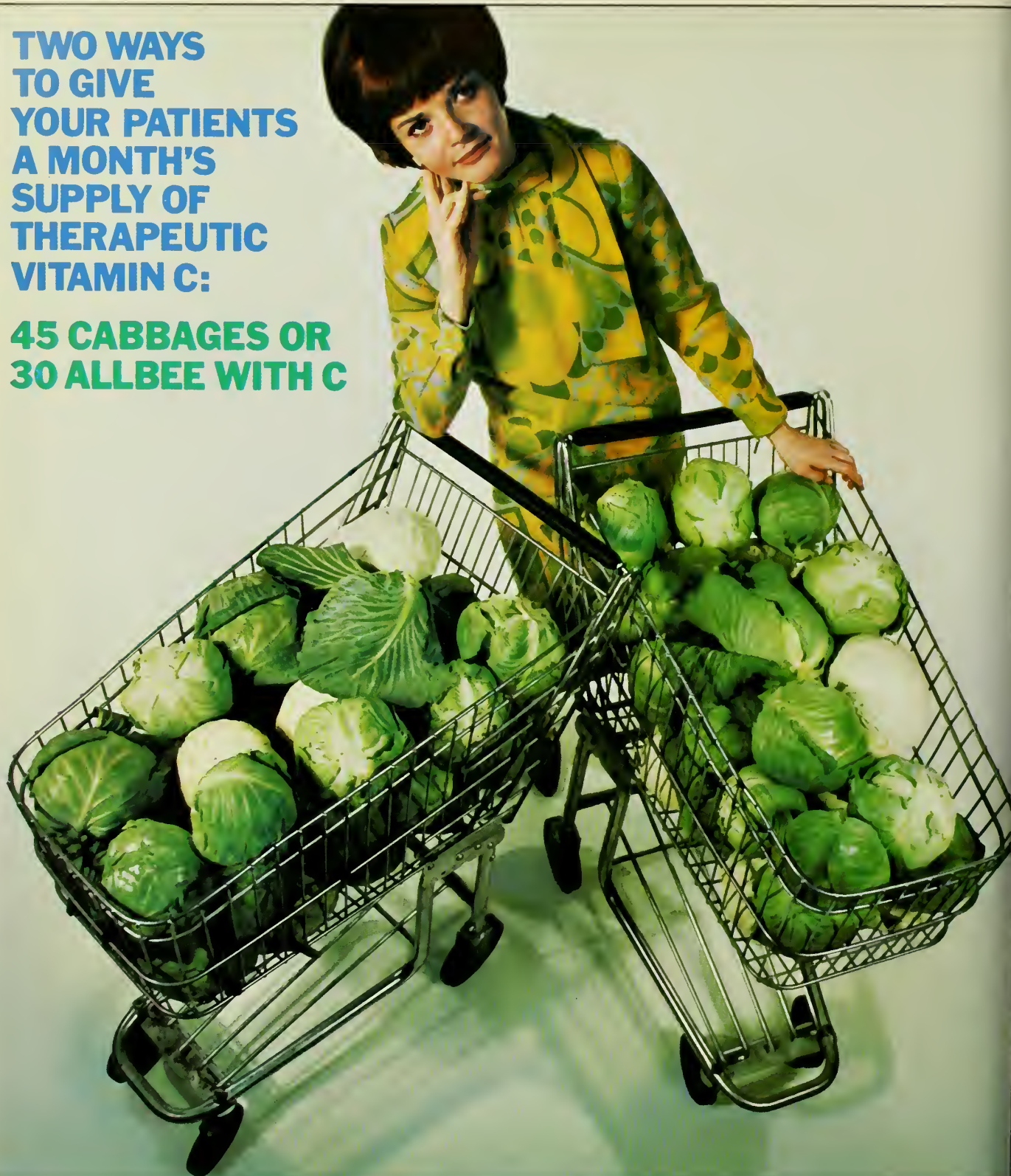
"the Donnatal Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
phenylephrine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
propine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
phenobarbital	0.0065 mg.	0.0065 mg.	0.0195 mg.
	($\frac{1}{4}$ gr.) 16.2 mg.	($\frac{1}{2}$ gr.) 32.4 mg.	($\frac{1}{2}$ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

**TWO WAYS
TO GIVE
YOUR PATIENTS
A MONTH'S
SUPPLY OF
THERAPEUTIC
VITAMIN C:**

**45 CABBAGES OR
30 ALLBEE WITH C**



Your patient would have to eat 45 cabbages a month (1-1/2 a day) to get as much vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak.

Write "30" for B and C deficiencies. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

A. H. Robins Company, Richmond, Va. 23220.



A-H ROBINS

Each capsule Contains:
Thiamine mono-
nitrate (Vit. B₁) 15 mg
Riboflavin (Vit. B₂) 10 mg
Pyridoxine hydro-
chloride (Vit. B₆) 5 mg
Niacinamide 50 mg
Calcium pantothenate 10 mg
Ascorbic acid (Vit. C) 300 mg

Allbee[®] with C

30 Capsules



Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids. **SPHENOID SINUS**—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB



Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. Sinutab *not only* provides an effective decongestant — to reduce mucosal engorgement and facilitate freer breathing — *and* an antihistamine — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, two analgesics for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA **SINUTAB**[®] FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab[®] with Codeine.* Each tablet contains 15 mg. ($\frac{1}{4}$ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab[®] Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.



WARNER-CHILCOTT Morris Plains, N.J.

S-1N-81-4C

Summary of
**OFFICIAL
REPORTS
1968**



PENNSYLVANIA MEDICAL SOCIETY
LEMOYNE, PENNSYLVANIA

SUMMARY 1968 REPORTS

PENNSYLVANIA MEDICAL SOCIETY

All items appearing in this special section of *PENNSYLVANIA MEDICINE* are summarizations of the 1967-1968 annual reports. Complete annual reports, including the Auditor's Report, are included in the *Official Reports to the House of Delegates* booklet, copies of which are available upon request.

BOARD OF TRUSTEES AND COUNCILORS *William A. Limberger, M.D.*

This report summarizes significant actions of the Board as outlined in the 1968 Annual Report of the Board of Trustees.

The Board:

Determined to oppose vigorously proposed amendments to the Articles of Incorporation of Philadelphia Blue Cross which would give Blue Cross the right to pay for physicians' services.

Reduced the mortgage on the Headquarters Building from \$150,000 to \$125,000.

Selected the Marriott Motor Hotel, Philadelphia, as the headquarters for the 1969 meeting of the House of Delegates (October 8-12); authorized a socioeconomic conference to be held in conjunction with this meeting.

Determined to discontinue the present Officers' Conference in favor of a new spring meeting which would differ in approach and basic objectives.

Adopted the recommendations of its Special Task Force on Medical Education to consolidate all the Society's educational activities under the aegis of one administrative unit—a Council on Education. Directed the Committee on Constitution and Bylaws to prepare amendments to implement these recommendations.

Authorized the Educational and Scientific Trust to broaden its horizons to seek monies to finance and implement programs desired by the Society which would otherwise work financial hardship on the Society.

Changed the name of the Commission on Health Facility Planning to the Commission on Comprehensive Health Planning and informed the Secretary of Health of the Society's desire to have the Commission serve as

a medical advisory committee to the State Advisory Council on Comprehensive Health Planning.

Approved the presentation of a trial socioeconomic course to interns and residents at one community hospital and one university-oriented hospital. This course is to be sponsored by the Council on Public Service.

Directed that the Commission on Rural Health be discontinued at the conclusion of 1968 and that the Council on Public Service assume the functions of the Commission.

Endorsed the five proposals adopted by the Pennsylvania Constitutional Convention.

Took the following position with regard to marijuana: "That marijuana is a dangerous drug; that medical treatment, rather than prosecution or incarceration, is mandatory for persons who become seriously involved in the use of this drug; that persons who prepare, distribute, or sell this drug should be prosecuted."

Supported Governor Shafer's recommendations to increase public assistance grants to 90 percent of the state's own health and decency standards.

Voted to support H-2314 (Uniform Anatomical Gift Bill).

Determined to inform the Senate Committee to Investigate Problems Concerning State General Hospitals of the Society's long-standing opposition to the continued operation and management of general hospitals by the Commonwealth.

Commended Governor Shafer for his program to provide optimal environmental conditions for the health of citizens of the Commonwealth and urged the legislature to take the necessary action to implement the plan.

SECRETARY *Allen W. Cowley, M.D.*

As I noted in my report to the 1967 House of Delegates, for the first time in many years we had activity on the part of District Boards of Censors and this year we continued to maintain a steady pace. Meetings of the District Boards of Censors of the First and Eleventh Councilor Districts were held to hear appeals by individual members regarding actions of county medical societies.

I have attended meetings of the Board of Trustees and continue to be consulted by the administrative staff concerning details regarding the responsibilities of the office of the Secretary. Our office receives many requests for legal opinions from county medical societies, hospital staffs, and individual members. These matters are referred

directly to legal counsel for comment unless we already have an opinion on file.

JUDICIAL COUNCIL

The Judicial Council held a reorganization meeting immediately following the adjournment of the 1967 House of Delegates. Lewis T. Buckman, M.D., of Wilkes-Barre, was elected chairman, and Russell B. Roth, M.D., of Erie, was elected vice-chairman. The Judicial Council convened in official session in Pittsburgh in November 1967 to hear an appeal from the Washington County Medical Society regarding an opinion rendered by the

District Board of Censors of the Eleventh Councilor District. In addition, at the request of the Board of Trustees, the Judicial Council considered Resolution 67-9 re Unjustified Restriction of Hospital Privileges. The Council rendered an opinion in this matter and this matter is discussed in the report of the Board of Trustees to the House of Delegates.

MEDICAL DEFENSE

During 1967, nine applications for medical defense were filed and approved. From January 1, 1967, to May 31, 1968, ten medical defense cases were closed for a total

cost to the Society of \$10,072.52. As of May 31, 1968, there are thirty-nine medical defense cases in our files by councilor districts as follows:

First:	8	Seventh:	1
Second:	13	Eighth:	0
Third:	2	Ninth:	0
Fourth:	2	Tenth:	11
Fifth:	0	Eleventh:	1
Sixth:	0	Twelfth:	1

In eighteen of the cases listed above, physicians involved do not carry malpractice insurance.

EXECUTIVE DIRECTOR *Lester H. Perry*

The 1967-68 year provided the Society with experience in a new area—the administration of the Susquehanna Valley Regional Medical Program. The Program is financed by the Federal Government under P. L. 89-239, the Heart, Cancer, and Stroke Legislation passed in 1965. This direct involvement in the planning of a federally funded health care program is symbolic of the social climate in which physicians must practice today. For better or for worse, the events of the past few years have brought organized medicine at all levels into a new era of great challenge. To meet this challenge, your officers and trustees, the members of your councils, committees, and commissions, and your staff have endeavored to mold the partnership with government into a workable, practical, and acceptable pattern.

The Society's involvement with SVRMP and the other new governmental programs such as Pennsycare has in no sense diminished the broad range of its normal activities. All actions taken by the House of Delegates and Board of Trustees, amounting to literally hundreds of policy decisions during the past year, have been implemented or are in the process of being implemented. The annual reports of the Board of Trustees, the councils and the committees reflect many of the details involved in the fulfillment of these policy decisions by concrete action.

Despite the Society's increasing responsibilities, I am pleased to report that our regular administrative staff totals thirty-eight persons as compared with the total of forty-one which I noted at the time of my last report. This decrease in the number of staff has been made possible by the realignment of responsibilities among staff members as the nature of the Society's activities in several areas has changed, by an increase in responsibility for newer staff members who have matured and developed, and by the efficiency of computerized billing procedures initiated in 1965.

To carry out the work of the Susquehanna Valley Regional Medical Program, the Society has seventeen additional employees who are located in a separate building approximately two miles from our headquarters in Lemoyne. The financial burden of this part of the Society's operation is borne entirely by the Federal Government. The Society is also reimbursed by the Government for the management and bookkeeping services as well as other indirect costs incurred in conjunction with the program.

In 1968 dues statements were prepared by means of data processing equipment for fifty-eight county medical societies and, as a consequence, sharply reduced the time

involved at the county level. Each year the techniques become more refined and flexible. In practical terms this means that we can offer the county societies more services in this area and still reduce the total time it takes to produce them. This year computers printed membership cards, AMA membership reports, membership lists of the individual county medical societies, and address labels.

The Society has experienced another slight increase in the number of members who pay full dues (from 10,724 to 10,733), but there was a slight overall decline in total membership (from 12,243 to 12,233). It is encouraging to note that the Society attracted 467 new members in 1967 as compared with 440 new members in 1966.

PENNSYLVANIA MEDICINE must operate according to sound business practice, publish what the members most need to know, and fire that presentation with sufficient imagination to get and hold attention. With the guidance of the Committee on Publication, the editorial staff has concentrated on creating a better balance among these three essential elements. The result has been marked progress in all three areas. Recently, for example, the editorial staff of PENNSYLVANIA MEDICINE has presented more news about events which affect the practice of medicine while at the same time striving for excellence in the quality of its scientific papers.

Advertising revenue in 1967 increased almost 25 percent over that of 1966, and our experience for the first six months of 1968 portends another increase over last year. Our improvement in advertising income is coupled with another significant change involving printing costs. Such costs have been increasing regularly for many years, but reversal of this trend is in store for 1969. At the beginning of 1968, a number of printing firms in Central Pennsylvania were invited to submit bids for printing PENNSYLVANIA MEDICINE. The extremely competitive nature of the bids has resulted in a printing contract for 1969 which reflects a lower unit cost than is currently being absorbed by the Society.

We are currently in our second year of operation at the new headquarters building located in Lemoyne just across the Susquehanna River from Harrisburg. Although our facilities are larger, expenses for the year 1967 and the first six months of 1968 indicate that operation and maintenance costs are being kept well within reasonable limits. A cordial invitation is extended to all Society members to visit the headquarters office whenever they are in the Harrisburg area.

The customary examination of the Society's accounts as of December 31, 1967, was performed by Main, Lafrentz & Co., Certified Public Accountants, and the report of their audit is being submitted to all members of the House of Delegates. It is available to others upon request.

The Society's resources are contained in five separate funds. Four of these funds are earmarked for special purposes and are not available for current operating expenses.

The annual dues of our active members (excluding residents and senior members) for the year 1967 were \$75. Of this total, however, only \$64 was available to the General Fund for the operating expenses of the Society. By action of the House of Delegates, \$11 per member was allocated as follows: \$8.00 to the Educational and Scientific Trust for loans and scholarships and \$3.00 to the Medical Benevolence Fund.

The General Fund is the active functioning account for the day-to-day operation of the Society's various programs. During 1967 income for this account (derived chiefly from dues, advertising in *PENNSYLVANIA MEDICINE*, commercial exhibits and registration fees at the convention, and investments) amounted to \$856,107. Expenses for 1967 totaled \$801,865. With income of \$856,107 and expenditures of \$801,865, the Society ended the year with a surplus of \$54,242.

The Medical Defense Fund had assets totaling \$94,704 at the end of the fiscal year. The cash balance from 1966 and the income on investments did not provide sufficient funds to cover all the expenses for the year; consequently,

the Board of Trustees appropriated \$10,885 (a sum equal to \$1.00 per active member) so that the Fund could meet its obligations.

The Medical Benevolence Fund consists of investments and savings totaling \$533,169, which yielded \$25,488 in income during 1967. The Fund also received \$2,378 from the estate of a deceased beneficiary. These two items added to the allotment from dues of \$32,490 were used for making payments to beneficiaries of the Fund. The capital of this Fund was increased by contributions totaling \$8,978.

At the beginning of 1967 the Contingency Reserve Fund was valued at \$118,105. By the end of the year this Fund had been reduced by the sale of securities totaling \$46,983, which was transferred to the Building Fund in order to keep the amount of the mortgage on the new building at \$150,000. The Fund suffered a loss of \$1,722 on the sale of investments which reduced the value to \$69,400 by the year end. The Board of Trustees has since taken action to transfer the balance of the 1967 surplus (after reducing the mortgage to \$125,000) to the Contingency Reserve Fund.

The Property and Equipment Fund includes land and building valued at \$777,295 and furniture and equipment valued at \$87,148. Reserves for replacement of both the building and the furniture and equipment accounted for \$33,856. A small amount of cash (\$3,160) still remained in the Property and Equipment Fund on December 31, 1967, to be used as part of the final payment to the contractor. The total value of the Property and Equipment Fund at the close of the fiscal year was \$901,459.

SUMMARY REPORTS OF INDIVIDUAL COUNCILORS

FIRST COUNCILOR DISTRICT *A. Reynolds Crane, M.D.*

Fortunately there are two excellent sources for material as one contemplates writing a description of the activities in a medical community as large, diverse and active as the First Councilor District (Philadelphia County Medical Society). The first of these is *Philadelphia Medicine* which is published twice a month under the able editorship of Donald C. Geist, M.D. However, this publication is of such interest and has such a useful content that a goodly portion of time has already been used in getting lost in the interesting reading contained therein. The other source is Mr. William F. Irwin, the able executive secretary who has his fingertips not only on the history of this society but its current activities as well. In reviewing the list of committees, their activities and the activities of the society one cannot but be impressed by the effort devoted to the public good, community health if you will, and equally impressed by how many of the activities are of a worthwhile nature.

The 1967-68 year has been an active and productive one for the Philadelphia County Medical Society. Starting under the imaginative and concerned leadership of John V. Blady, M.D., the pattern continued under Katharine

Boucot Sturgis, M.D. who was inducted as the Society's president in January of this year, the first woman to hold that office in the 119 year history of the Society. With a keen interest in the problems of the public health, a sense of the practical tactic and an enthusiastic persistence, her regime is accomplishing much that is useful in the present era of euphoric governmental planning.

In the field of community affairs one may first refer to the effective health fair held last year under the able direction of Malcolm W. Miller, M.D., for which the County Society received a citation from the Philadelphia Chapter of the Public Relations Society of America. The effectiveness of this project has already led to the development of plans to hold a second health fair in 1969. In this same vein the society sponsored a community health week program from October 15 to 21 in which many of the local health agencies participated. This was followed by the society's acting as co-sponsor of a "Health-O-Rama" held in a shopping center in North Philadelphia. To further help the general public in its health matters, an annual conference on nutritional metabolism was held by the County Medical Society in October of 1967. In

addition a Diet Counselling Service has been set up to which individuals may be referred by physicians for the help of dietitians in the control of their dietary problems in specific disease states such as diabetes and renal disease and also in the general nature of the problems of obesity. A new committee on Community Affairs is studying the responsibility of the medical profession to problems of community health and Dr. John Blady is the society's representative on the Executive Committee of the Regional Comprehensive Planning Effort. The problem of air pollution is a particularly serious and urgent one here and the Society's Committee on Air Hygiene under the chairmanship of Herbert Dietrich, M.D. is working assiduously to effect some degree of control of this situation. The Society was very effective in having all nurses and physicians working in pediatric wards and newborn nurseries receive studies for active tuberculosis through tuberculin tests and chest x-rays, following an outbreak in a neighboring state. Through the activities of the Society's Committee on Dependent Diseases concerned with addiction and drug misuse a separate hard narcotic facility will be established at the Philadelphia General Hospital. The role of this institution in the future of medical care is under careful study by a special group on which the Society is well represented by Charles Thompson, M.D. The question hinges around the role of a public charitable institution in an era in which all patients are to be regarded as private patients but with the government supporting their medical care. The annual disaster drill was held on May 1, 1968 and covered the entire Philadelphia area. This is a remarkably effective effort and much credit is due to the Chairman of the society's Committee on Disaster Medicine, William F. Bouzarth, M.D. As with other components of the State Society the First Councilor District is much concerned about the status of blood, tissue and organ transplants and having these removed from the area of commercial code warrantees. We have urged the passage of Senate Bill 1384 to assure that such medical procedures and particularly blood transfusions shall continue to be recognized as the complicated scientific procedures they are.

Recognizing the contributions of others to the general health of the community, the Rohm and Haas Company of Philadelphia was presented with an occupational health award in December of 1967 at the meeting of the Industrial Medical Association of Philadelphia. Citations were also given to the Police and Fire Departments for the excellent emergency medical services they maintained in Philadelphia. In the area of medical education Charles A. Hofnagle, M.D., professor of surgery at Georgetown Medical School delivered the annual DaCosta Oration in October 1967 on the subject *Artificial Heart Valves, Past, Present and Future*. The annual Pfahler Oration was given during the Annual Post-Graduate Institute by Ernest H. Wood, M.D. of the Neurological Institute of New York on the subject *Thermography in Cerebrovascular Disease*. The society's 45th annual Strittmater award was conferred upon Jonathan E. Rhoads, M.D., professor of surgery at the University of Pennsylvania in April of 1968. At this same time John H. Harris, M.D. presented certificates to fifteen physicians in recognition of fifty years of medical practice as well as certificates to six members of the society who have served effectively as members of the State Society's Speaker's Bureau.

In addition to the above the Society has sponsored a series of one-minute programs over a local radio station answering questions on health subjects sent to the station by the public. The Woman's Auxiliary with Mrs. J. Stauffer Lehman as President, has continued its efforts sponsoring the 38th Annual Health Institute on March 27, 1968 to a capacity audience, at which time the subjects of headache and smoking were discussed. In the education of physicians, the Society approved and sponsored a course in proctosigmoidoscopy for practicing physicians to be given in various hospitals and clinics. An interesting effort has been that of Dr. Sutnick and the Committee on International Medical Graduates who have addressed themselves to the problem of instruction in colloquial English which will enable foreign graduates in schools and working in various programs in Philadelphia to better cope with the practicalities of every-day medical practice. The Committee on Medical Education under Dr. Brecht is considering the possibilities of a self-assessment program for physicians but much ground work remains to be done before specific recommendations are made. The very successful Post-Graduate Institute with a program arranged by Robert Mayock, M.D. and Charles Shuman, M.D. was held on February 20-23 of 1968. Despite the effectiveness of this program the society is critically evaluating its role in the field of post-graduate medical education, particularly with reference to the various projects in the offing under the auspices of the Regional Medical Program concept. The committee on Medical Economics under Robert Tyson, M.D. has met with the Insurance Commissioner on the problems related to malpractice insurance. It is also investigating the feasibility of the Society's arranging for coverage under auspices which would permit participation in the evaluation of an individual's insurability by the Society. The Society in conjunction with the Blue Cross of Philadelphia and the Delaware Valley Hospital Council has initiated a task force to study the rising cost of medical care and hopefully will bring forth recommendations which will be useful in this area. Because of the activities of various third parties in the covering of health needs, a special committee has been formed to study the future of private practice, which may well be influenced, it would appear, by the ever increasing role of the hospital as a focus of medical practice. Drs. Blady and Sturgis participated in public hearings before the Insurance Commissioner in connection with an application by Philadelphia Blue Cross for an increase in its rate structure.

The membership of the Society now consists of 3,170 active members, 167 new physicians having been elected in the past year. In addition to this there are 344 associate members and 534 affiliate members for a total membership of 4,049. This is a reassuring increase in the membership over the previous year and is in no small part due to the great effort and able work of the Committee on Membership and Society Organization, with David S. Crystal, M.D. as its Chairman. The seven Branch Societies have again served as a sound and strong focus of activity and, with Board representation, take a responsible role in the affairs of the Society.

Once again this report touches upon but a few of the many activities and accomplishments in the First Councilor District. There are no items which require action.

SECOND COUNCILOR DISTRICT *William A. Limberger, M.D.*

Two meetings of the Second Councilor District were held during the year: the first prior to the first meeting of the House of Delegates at the Annual Session, and the second on May 18th, 1968 at the Tally-Ho Restaurant and Hotel, Route 202.

The Second Councilor District Review Committee held six meetings during the year and reviewed seventy-nine cases for Blue Cross of Greater Philadelphia, Blue Shield of Pennsylvania, commercial insurance companies and CHAMPUS.

Continued activity, growth in membership and programs for improving the health of their citizens have characterized all of the six county societies in the district.

BERKS COUNTY

The Fellowship Committee staged another old fashion outing and clam bake for the September meeting of the Society which was a great success.

Pennsycare or Title XIX was the subject of the September meeting with panel representation from the State and County Medical Societies.

A medical Explorer Post of the Boy Scouts was sponsored by the Society. The Health and Educational Trust of the Society granted a medical scholarship loan to S. Neitz Seibert, a student at Jefferson Medical College. The Health and Educational Trust also approved a grant to extend the fluoridation of the county water supplies through educational and scientific assistance.

At the annual Business Meeting of the Society in December, Arlington A. Nagle, M.D. was installed as President for 1968 by Irving Imber, M.D., retiring President.

The 86th Annual Banquet was held on January 10th at the Reading Motor Inn. New Member plaques were presented to nine physicians who joined the Society in 1967, and a Pennsylvania Medical Society Fifty Year Award was presented to Walter W. Werley, M.D. Merit award plaques were presented to Irving Imber, M.D.; Arnold V. Davis, M.D.; R. William Alexander, M.D., and Ethan L. Trexler, M.D.

The Society is playing an active role on the Steering Committee of the East Central Pennsylvania Planning Committee for implementation of PL-89-749.

The Council on Public Service has had a very active year, particularly in the fields of air pollution control, medical disaster tests, medical self-help programs, and first aid courses.

Interesting Society programs included: *Psychiatry and the Law* at the February meeting at Wernersville State Hospital; *Your Society's Group Insurance Program* at the March meeting and *Music—A Therapeutic Agent* at the May meeting.

BUCKS COUNTY

The County Society is represented on the Bucks County Planning Committee by Charles W. Burmeister, M.D. and Richard L. Schumacher, M.D. The Building Fund, which has been accumulating and now has a balance of \$27,000, will be kept intact. There are no plans for building in the near future.

A Measles Program was approved at the November

meeting and held in April under the joint auspices of the Society and the Bucks County Department of Health. The program was two-phased, with the first two weeks devoted to immunizing the children in the physicians' offices and the Well Baby Clinics, followed by a "mop up" operation during which several stations for mass immunizations were opened on one or more Sunday afternoons.

At the December meeting the Nominating Committee presented its slate for 1968 which included Elmer E. Mears, M.D. for President; Richard E. Fox, M.D., Vice-President; and Joseph T. Ichter, M.D., Secretary-Treasurer.

George W. Shaffer, M.D., President of the Society, presented the Bucks County Medical Society Benjamin Rush Group Award to the Village Improvement Association which, among other activities, own and operate the Doylestown Hospital.

Elmer E. Mears, M.D. was installed as President at the January meeting by retiring President, George W. Shaffer, M.D. The Society approved the purchase of "Resussi-Anne," a life size model that can be used for demonstrating mouth-to-mouth artificial respiration and closed chest cardiac massage. It was given to the Woman's Auxiliary which will supervise its operation and maintenance.

A joint meeting with the Bar Association of Bucks County was held at the Doylestown Country Club on March 13th with H. Keith Fischer, M.D., Clinical Professor of Psychiatry at Temple Medical School, speaking on *Doctors and Lawyers from the Psychoanalyst's View*.

A Disaster Program was presented at the April meeting in preparation for the Medical Disaster Drill on May 1st in which five hospitals participated.

The May meeting was a joint meeting of the Society and the clergymen of the County with a panel of clergymen conducting a question and answer program with the physicians on mutual problems.

CHESTER COUNTY

Wyeth Laboratories at Radnor was the host for the September meeting and a tour of the research facilities of the Laboratories followed the business meeting of the Society.

On Sunday, October 22, 1967, the Society, in cooperation with the State Department of Health, conducted a county-wide Measles Vaccination Campaign with clinics held at thirteen schools from 1:00 to 5:00 P.M. forty-five hundred children were immunized.

The Annual Meeting of the Society was held on January 17th at the Covered Wagon Inn, Strafford. William F. Beyer, M.D. was inaugurated as President for 1968. The Chester County Medical Society Benjamin Rush Individual Award was presented to Mrs. Mercedes Greer of West Chester and the Group Award to the Avon-Grove Lions Club.

The Annual Joint Meeting with the Chester County Bar Association was held on February 21, 1968 at the Ship Inn, Glen Loch. A panel of lawyers discussed medical depositions as opposed to the physical presence of the doctor in court.

The Veterans Administration Hospital at Coatesville was host for the March meeting. The Committee on Medicine and Religion was responsible for the meeting and presented Chaplain Walter T. Smith of the central office of the Veterans Administration who spoke on *Pastoral Counseling—A Resource for Community Health.*"

A ten weeks' course in *Emergency Care and Transportation of the Injured* was conducted by the Public Health Association of Chester County in conjunction with the Medical Society. Over fifty ambulance drivers, police, and industrial nurses took the course.

The Committee on Emergency Medical Services supplied the roster of examining physicians for the Chester County Council of Boy Scouts for medical inspection of Scouts entering Camp Horseshoe for their encampment.

DELAWARE COUNTY

A meeting of the Society with eighty-five school administrators and personnel engaged in Adapted Physical Education in the Delaware County schools was held in September.

The Marcus Hook Refinery of the Sun Oil Company was host to the Society for its October meeting. A tour of the plant, followed by dinner was climaxed by a program outlining the Sun Oil Company's world-wide medical program.

The "Knock Out Measles" program was held on October 29, 1967 with twelve clinics open from 1:00 to 5:00 P.M. It was held in conjunction with the Pennsylvania Department of Health and the Delaware County Medical Society Public Health Fund. Five thousand ninety-eight children were immunized.

The County Society Occupational Health Award was presented to the Westinghouse Electric Corporation for providing outstanding medical services to its employees.

A Membership Indoctrination Dinner was held at the Media Inn preceding the December meeting for all members who joined the Society in 1967.

The Annual Dinner Meeting of the Society was held on January 20th at the Alpine Club, Springfield. Arthur H. Silvers, M.D. was inaugurated as President for 1968. Ernest L. Noone, M.D. was presented with a special certificate for his untiring efforts as Chairman of the Commission on Medical Disaster, and Ralph H. De'Orsay, M.D., retiring President, was presented with a silver tray for his fine leadership during 1967.

A ten weeks' course of the Delaware County Ambulance Training Program was started at the Thomas Fitzgerald-Mercy Hospital in March with Joseph McGee, M.D., Chairman of the Commission on Medical Disaster, in charge. Over seventy applicants registered for the course.

A joint meeting with the Women's Auxiliary and the clergy was held in March when a motion picture entitled *LSD 25* was shown to the group. Paul J. Fink, M.D., associate professor of psychiatry, Hahnemann Medical College and Hospital, discussed the picture and his experiences in treating patients who had taken LSD.

The Society's annual medical scholarship of \$1000 was given to Miss Frances Stewart of Drexel Hill who is graduating from Duke University and will enter Woman's Medical College in the fall.

LEHIGH COUNTY

Eleven interns of the Allentown Hospital presented a panel discussion of *Current Concepts of Diabetes* at

the October meeting. Dean Dimich, M.D., chief of medicine at the Allentown Hospital, acted as moderator for the panel.

The Annual Business Meeting was held in December at the Lehigh Valley Club. The Nominating Committee presented its slate of officers for 1968 which included Robert J. Beitel, M.D. for President and E. John Stahler, M.D. for President-elect.

The Annual Inaugural Banquet was held on Saturday, January 20, 1968 at the Holiday Inn of Bethlehem with over three hundred guests in attendance. John H. Harris, M.D., President of the Pennsylvania Medical Society, addressed the Society. Nineteen physicians who joined the Society were introduced. Plaques were presented to nine physicians by the Executive of the Lehigh County Council of Boy Scouts of America for their interest and concern in the health of the boys who attended the summer camp in 1967. Pennsylvania Medical Society Fifty Year awards were presented to Henry E. Guth, M.D., Charles R. Fox, M.D., and Paul C. Shoemaker, M.D. A Distinguished Service Award was presented to Morgan D. Person, M.D. in appreciation of continued valuable service to the community and the Society over a number of years. Robert J. Beitel, M.D. was inaugurated as President by Frank J. DiLeo, M.D., Secretary of the Society.

The Benjamin Rush Award luncheon was held on Wednesday, March 20th, at the Lehigh Valley Club. The Individual Award was given to Mr. Earl Hunsicker and the Organization Award was given to the Junior Women's Club of Allentown.

On April 23, 1968 the Exchange Club of Allentown presented its Annual Golden Deeds Award to Hope Ritter, M.D. who retired from practice on January 1st, 1968 at the age of eighty-nine years after sixty-five years of valuable service to the citizens of Allentown.

The 86th Annual Meeting of the Lehigh Valley Medical Society was held on May 15th with an all day symposium on *Sexual Problems in Clinical Practice.*

MONTGOMERY COUNTY

The Executive Director of the Charles Johnson Home, the Montgomery County Home for the Aged, addressed the Society at the September meeting, and described the addition of 200 beds with a new hospital.

The joint Dinner Meeting of the Society with the Montgomery County Bar Association was held on October 11, 1967 at the William Penn Inn with Jimmy Dykes, well known athlete and radio commentator as speaker.

Through the Looking Glass to the Not-So-Alien World was the subject of the scientific program at the Norris-town State Hospital in December. Representatives from each of the departments in the hospital presented capsule summaries of their efforts in attaining continuous patient care.

The Nominating Committee presented its slate of officers for 1968 at the December meeting which included Edwin S. Carlin, M.D., for President, and Frank J. Tornetta, M.D., for President-Elect.

The Annual Business Meeting with election of officers and installation of the new President was held on January 10, 1968 at the Medical Society Building. Samuel F. Cohen, M.D., Chairman of the Commission on Forensic Medicine, reported excellent cooperation with the Medico-

Legal Relations Committee of the Montgomery County Bar Association.

An intensive campaign for immunization of children from measles through pamphlets, radio announcements and press releases was conducted by the Committee on Public Health and Preventive Medicine with the result that the Committee felt a mass immunization program was unnecessary.

Medicine-Religion month was observed at the March meeting with Major Wayne B. Shelton, Chaplain of the Valley Forge General Hospital, speaking on the subject *Clergyman—Member of the Healing Team*.

The County Society Individual Benjamin Rush Award was given to John Carlton of the Atlantic Go-Patrol with the Group Award winner given to the Atlantic-Richfield Company.

Mr. Ward Bently, Area Coordinator, and Mr. Homer B. Glover, Area Liaison Officer of the Greater Delaware Valley Regional Medical Program, discussed the part which

county medical societies and individual physicians are urged to take in the planning and implementation of this program.

The Annual Dinner of the Society was held at Milo's Country House, Limerick on June 5, 1968. The guest speaker was Robert Long, M.D. of Louisville, Kentucky, Trustee of the American Medical Association.

The County Society's 1968 Medical scholarship award was given to Miss Anna Maria D'Amico of Conshohocken, a graduate of the Catholic University of America, Washington, D.C. She will enter Jefferson Medical College in the fall. The Pennsylvania Medical Society's Fifty-year Award was presented to C. Harold Kistler, M.D. of Ardmore for faithful and valuable service to the citizens of the county. Arthur D. Nelson, M.D. was presented with a plaque from the Speakers Bureau of the Pennsylvania Medical Society for his numerous speaking engagements during the past year.

THIRD DISTRICT *Joseph A. Walsh, M.D.*

The following is a summary of the activities of several of the county societies comprising the Third Councilor District:

CARBON COUNTY

The Carbon County Medical Society sponsored a measles clinic under the direction of E. E. Laigon, M.D. of Coaldale in which 2,023 immunizations were given throughout the County. This clinic was well attended, quite successful and engendered much good in public relations.

Dr. & Mrs. Laigon attended the PaMPAC meeting in Harrisburg representing this Society and reported that it was an excellent and informative session.

LACKAWANNA COUNTY

A great part of the activity of a large number of the 245 members of the Lackawanna County Medical Society during this past year involved planning and participation in continuing education through Society, hospital and federally oriented programs. In conjunction with these activities, seminars were conducted not only for physicians but for other community groups in cooperation with the Medical Society.

A very successful Medicine and Religion meeting was held in the spring and featured the Rev. Dr. Paul B. McCleave, director of the AMA's Department of Medicine and Religion. This meeting was sponsored jointly by the Society with the Lackawanna United Churches, the Scranton Catholic Diocese and the Lackawanna Rabbinical Union. Another highlight of the program was a panel discussion on the *Problem of the Unwed Mother* in which a physician, Nestor G. deQuevedo, M.D. participated together with a clergyman, a social worker and a supervisor of case work at one of the local maternity hospitals. George E. Pugh, M.D. the Society's Medicine and Religion Chairman, is to be commended for this excellent seminar which was open to nurses, guidance counselors, social workers and other paramedical personnel. A further major seminar on Medicine and Religion is planned for the near future.

In further cooperation with allied organizations, the Society held a joint scientific meeting with the Scranton District Dental Society and the Lackawanna County Pharmaceutical Association. Another special program was presented at a socio-economic meeting at which prominent local attorneys and insurance executives were guest speakers. John H. Harris, Sr., M.D., President of the Pennsylvania Medical Society was another special guest speaker and addressed the members at the Society's annual banquet. In addition, the regular monthly scientific meetings were held, with prominent physicians and medical educators as guest speakers.

Medical Society endorsement was given to a professional education program of the N.E. Council on Alcoholism and to the Pennsylvania Bar Association's Institute on *How to Prepare and Prove Medical Evidence*. Local physicians assisted with both programs. During the past nine months several Lackawanna County physicians have also been deeply involved in the planning and organizational programs of the Greater Delaware Valley Regional Medical Program for this area. The Comprehensive Health Planning and Public Health Service Amendment (P.L. 89-749) has also been of regional interest with Joseph A. Walsh, M.D., one of the Society's members and the District's Trustee and Councilor, named official representative to the program.

Under the chairmanship of Eugene G. Stec, M.D., a county-wide Emergency Medical Disaster Plan was organized and all able physicians were assigned to designated hospitals and stations to prepare for the possibility of an emergency medical disaster. The first Voice of Medicine Awards were formally presented by the President, Myron H. Ball, M.D., to Joseph A. Walsh, M.D., and to Nestor G. deQuevedo, M.D., a Past President of the Society, for their contribution in making medicine's viewpoints known. The Society publication became *Lackawanna Medicine* (formerly *Medical Society Reporter*), taking on a new format and a new editor, Mario N. Fabi, M.D. The new publication combines a scientific section with the traditional county news features. On the lighter side, the Society officially welcomed new members, as well as the return of Donald G. deQuevedo, M.D. from

military service at the "Spring Smoker." Members also enjoyed the annual stag summer outing.

Underlying the year's activities and accomplishments there has been an awareness and active protest of the inadequacies of the implementation of the Medicare program, particularly with regard to the discrepancies in the "usual and customary fees" and surgical assistant's fees under the Pennsycare program. The Lackawanna County Medical Society has supported and initiated such resolutions and has committed itself to seek clarification of the problems behind the inequities and shortcomings of the program as it affects physicians, particularly in the Commonwealth of Pennsylvania.

NORTHAMPTON COUNTY

The Northampton County Medical Society held monthly meetings from September, 1967 through June. At the majority of these meetings a speaker whose subject was scientific addressed the group and attendance was quite good. At the May meeting the Benjamin Rush award was given to Mr. Nicholas Dutko of Bethlehem, Pennsylv-

FOURTH DISTRICT *George A. Rowland, M.D.*

One dispute, regarding fees under Medicare, arose in the Fourth Councilor District during the past year. A meeting of the District Review Committee was held with almost all of the members present. Earnest consideration was given to the matter in question and the physician involved was heard so that the situation could be understood.

In closed session, the Committee reached certain conclusions, and made recommendations both to the carrier and to the doctor. Certain matters of principle were established which may be used as guidelines in similar situations in the future. The results of this first and so far only judicial effort of the Fourth Councilor District Review Committee were most satisfactory. It is fortunate that no other problems have arisen since this work is done gratis by the members of the Committee. Both the carrier and the federal government refuse to pay committee expenses, even though they request the service.

Relationships between the societies of this District have never been better. For many years physicians in this and surrounding areas have flocked to the annual Rea & Derrick seminar in November for which the Northumberland County Society acts as host. As usual this was very well attended and the District was honored by the presence of John Harris, Sr., M.D., President of the Pennsylvania Medical Society.

As usual, members of the Montour County Medical Society have often provided scientific programs for the other societies of the District. For the second year in a row the Northumberland and Columbia County Societies met jointly. This year the meeting was in Columbia County and an excellent attendance of members of both groups enjoyed good fellowship and an outstanding scientific presentation.

The principal problem facing the Fourth District is one that many medical societies hold in common these days. It is member apathy. All of the societies are faced with the joint challenges of attendance and participation.

For a number of years, the Columbia County Medical

vania for outstanding service in the blood bank field.

Perhaps the most important business to come before the Society was the passage of a resolution concerned with P.L. 89-749 and P.L. 89-239. The resolution recommends that at least two full-time practicing physicians from each sub-region be appointed to the regional planning committees established under these laws and that at least one full-time practicing physician from each sub-region be appointed to each regional executive committee established under these laws. This resolution was passed at the June meeting and will be forwarded to the State Medical Society for action at the Annual Session of the House of Delegates.

CONCLUSION

Unfortunately several county societies did not forward reports to me and accounts of their activities are not included above. I wish to take this opportunity to thank the officers and members of the county medical societies within the Third Councilor District for their cooperation and assistance during the past year.

Society has included a luncheon charge in its dues. In effect, each member, once he has paid his annual assessment, is sacrificing a free meal if he misses a meeting. This, combined with an advantageous location for meetings, convenient for almost all of the members, has maintained a fairly good attendance each month. Unfortunately, not so much can be said for participation in medical society activities. Interest in and attendance at PMS and AMA functions have been negligible. Year by year, it has become increasingly difficult to find members even willing to handle the relatively simple housekeeping duties of the society.

In a manner of speaking, the Montour County Society has solved the attendance problem very simply. The Society meetings have been combined with those of the Geisinger Clinic Staff; since 90 percent of the members are also members of that group, excellent attendance is the rule. Participation of these doctors in state activities has been decidedly better than those in the other counties, but the Secretary has informed me that attendance dwindles after the scientific sessions, and interest is minimal in social, economic, and political medical affairs.

Northumberland County has had an attendance problem for many years. To some extent this has been based on a true geographical difficulty since the doctors of that county are distributed widely, and travel, especially in winter, can be time-consuming and even dangerous. This Society holds three meetings in the spring, three in the fall, and none during the summer and winter. The scientific programs have been excellent as is the rule throughout the district. This new scheduling appears to have been a shot in the arm which has revived the operations of this Society. Unfortunately, the conduct of business is largely a one-man affair. There has been very little tendency for the membership at large to become actively involved.

Schuylkill County is faced with an even more difficult geographical and physician distribution than Northumberland County. It has also done away with winter meetings

and still presents top-notch speakers from the Philadelphia medical schools in the spring and fall. Although there are several active and interested members they sorely feel the lack of anyone with the devotion and willingness to handle routine problems of Joseph Leskin, M.D., the former Councilor.

In all of these counties there are able, serious, and well-directed physicians. Most of them are concerned with the problems of organized medicine. All of them are short of time and most of them are lacking the slight touch of masochism that makes a man willing to slave away at the many tasks that are necessary to keep a county medical society active and purposeful.

There has been some discussion of the problems of securing executive secretaries for groups of medium and small county medical societies. It would appear that the Fourth District is an ideal place for testing such an arrangement. It is a compact area with approximately three hundred physicians, almost all located along the sides of an equilateral triangle approximately forty-five miles on a side. I believe that an executive, at first paid jointly by the Pennsylvania Medical Society and the County Societies of this district, could handle routine society business. He could arrange for meetings of single societies

or groups of societies. He could act as publisher of the bulletins, or even better of one district bulletin which would have four editors and would contain news and notices for each county society.

Whether or not such an arrangement went on to the formation of a Medical Bureau or other urban-type benefits, an executive would provide a constant link with the Pennsylvania Medical Society. Members freed of the minutiae of office would be better able to undertake projects of scientific and community importance.

This district has been a backwater because it has been inaccessible except by secondary highways. This situation is now changing rapidly with major arteries of the interstate highway system traversing the area. Industrial expansion has already been observed and rapid population growth is certain to follow. A small-scale district medical society today could become a major factor in the health picture a few years in the future.

I recommend that the House of Delegates approve such a project in principle. If the societies involved concur the Board of Trustees could institute such a plan on an experimental basis. If the experiment proves as successful as I think it will similar arrangements may be made in many other parts of the state.

FIFTH COUNCILOR DISTRICT *David S. Masland, M.D.*

This year it has been my privilege to visit the Franklin, Cumberland, Perry, and Dauphin County Medical Societies and I find that each of these groups is continuing its position of leadership in our society. This has been the year in which we have seen the Susquehanna Valley Regional Medical Program develop into an operational program. All the medical societies in the fifth councilor district are included in this program and have been active in its organization and development.

ADAMS COUNTY

The Adams County Medical Society reports that they continue to have the problem of a tremendous influx of tourism, which is almost unique for our district. The Society and hospital have arranged to set up a 24-hour outpatient service at the hospital in order to try to meet this load. The County Society has joined with the staff of the Annie M. Warner Hospital in arranging for the establishment of a medical library in the hospital. In this society, as in several in our district, the grievance committee's activity has increased; and I find that the mechanism is functioning well. Most grievances seem to be satisfactorily disposed of. This society along with the Agriculture and Home Economics Extension Services set up a seminar concerning basic nutrition and weight control.

PERRY COUNTY

This small society has again been active; the secretary points with pride to an 80 percent attendance record for its meetings. This year it again was one of the first in the state to conduct immunization programs. It may be remembered that Perry County was the first to conduct a Sabin polio program and a diphtheria-tetanus program. This year the society held a measles immunization pro-

gram; 581 doses were given. This represented approximately 36 percent of the estimated number of eligibles.

LANCASTER COUNTY

The Lancaster County Medical Society gave support to publicizing and promoting the concept of the County Health Unit before this matter was considered by the voters of the county. The concept, unfortunately, was defeated. One-fourth of the membership enjoyed a two-day outing at Mystic, Connecticut. This county reports that Robert H. Craig, Jr., of the Pennsylvania Medical Society discussed with the society the functions of a lobbyist. It has increasingly become the custom of county societies to invite members of the executive staff to their meetings in order to learn about the activities of the state society and to transmit to the state society through these staff members the feelings of the county society. I highly commend this procedure.

The society along with the Woman's Auxiliary was privileged to hear the beginning of the annual Troy Schantz Memorial Lectures set up in honor of a local doctor lost in an automobile accident last year. Van Buren O. Hammitt, M.D. of Hahnemann Medical College discussed psychiatric measures. This society also conducted a measles immunization program along with the osteopathic and pharmaceutical organizations of the county and gave over 6,000 injections. A joint meeting was held with the Lancaster County Bar Association. A panel discussion on *Interprofessional Relations* was featured, and those attending also viewed the winning projects of the Science Fair, a public school project to encourage students with an interest in science.

DAUPHIN COUNTY

With the initiative and guidance of the Dauphin County Medical Society, a councilor district meeting was called

in Harrisburg to discuss regional medical care planning. The program consisted of an excellent panel of speakers who discussed regional planning from the standpoint of the medical schools, insurance companies, business, hospitals and the state society. Representatives from nearly every area of Dauphin County and the Councilor District attended, and I wish to extend my thanks to the Dauphin County Medical Society for preparing and carrying through this program.

FRANKLIN COUNTY

The Franklin County Medical Society carried on a very successful measles program and gave over 3,700 injections. I visited this society and had the privilege of giving a Fifty Year Award to George A. Poe, M.D., a fine physician who has served as a credit to the community and to the Samuel G. Dixon State Hospital with which he is associated.

SIXTH COUNCILOR DISTRICT *H. Thompson Dale, M.D.*

Another year has quickly gone by and I am pleased to report that I have had many pleasant experiences. I will try to recall some of the highlights of the past year.

We had our 2nd annual Councilor District meeting with the senior pre-medical students from Penn State and Juniata College on Thursday, February 15, 1968 at the Nittany Lion Inn in State College. Many physicians from all the five county medical societies (about 10 percent of councilor district physicians) attended. All five county society presidents were present and introduced. John H. Harris, Sr., M.D., President of the State Medical Society, gave an excellent talk and presented a film on *The History and Development of the X-Ray*. Next year we plan to have George E. Farrar, M.D., President-Elect of the State Society, come to a similar meeting planned for Thursday, February 20, 1969. His talk will be on interesting gastro-intestinal problems upon which he has been doing research. Please mark this date on your county society calendar of events.

On April 20, 1968 it was my privilege to represent the Councilor District and John H. Harris, Sr., M.D., President of our Society at the Northeastern Session of the 17th Annual Convention of Alpha Epsilon Delta, International Pre-medical Honor Society. Twenty-seven colleges and universities were represented at this excellent meeting. The changing medical curriculum was discussed by six medical school deans and associate deans and was quite stimulating. At the convention luncheon Carl B. Lechner, M.D. of Erie, our very able Medical Editor of *PENNSYLVANIA MEDICINE*, gave a challenging and interesting address.

On May 13, 1968 letters were sent to the five county society secretaries requesting annual reports and I am sorry to say I received a report from only one—the Clearfield County Medical Society (sent by William L. Howe, M.D., Secretary-Treasurer). I have received lists of the officers and committees from four of the five county societies. I am also pleased that I have been asked by three county societies to perform some duties during the past year and will report on these in connection with the activities of the individual county societies.

CUMBERLAND COUNTY

The Cumberland County Medical Society, in cooperation with Dickinson College, conducted a very excellent sports injury conference in December of 1967. It was well received and it is anticipated that such a conference may become an annual or semiannual event. Because of its close location, this society held its meeting in May at the headquarters building of the Pennsylvania Medical Society. The members of the society learned first hand from PMS staff members the functions of the state society and took a tour of the building. This was a most informative meeting and the members felt that it was quite helpful in creating better understanding and liaison between the Pennsylvania Medical Society and the county society. I would recommend that other county medical societies consider this kind of meeting; or, perhaps, that they at least send a large delegation to the Society at intervals for such meetings.

BLAIR COUNTY

In January, 1968 Mrs. Dale and I had the pleasure of attending the annual banquet, installation of officers and dance of this busy society and it was a delightful affair.

April 23, 1968 I had the privilege of attending a meeting to present a plaque to Richard B. Magee, M.D., for participating in the work of the Speakers Bureau of the State Medical Society. I also had the privilege of congratulating Arthur E. Pollock of Altoona, M.D., Chairman of the Advisory Committee to the Speakers Bureau of the Council of Public Service, for the fine job he has been doing.

CENTRE COUNTY

There were nine good county medical society meetings during the past year. In June, 1968 the annual Physicians', Pharmacists' and Dentists' Outing was held at the Centre Hills Country Club, State College, Pa. This society spent \$200 for advertising on five radio stations in Central Pennsylvania to encourage people to vote in favor of the constitutional amendments in the primary election on April 23, 1968. At the April meeting I presented J. Reed Babcock, M.D. with the Speakers' Bureau Plaque. We all were saddened by the untimely deaths of William L. Welch, M.D. of State College and L. D. Locke, M.D., of Bellefonte.

CLEARFIELD COUNTY

Mrs. Dale and I were pleased to attend the Annual Dinner-Dance on December 19, 1967. It was an excellent affair. This county society waged an active campaign to get a yes vote for the constitutional amendments in the April, 1968 election and wrote many letters to legislators requesting that chiropractors not be covered under "Pennsycare." Dorothea F. McClure, M.D., pathologist of the Clearfield Hospital, was elected "Woman of the Year" by the Woman's Club of Clearfield. Elmo E. Erhard, M.D. of Clearfield is President of the Penn-

sylvania Medical Golf Association. I am proud of this active society.

HUNTINGDON COUNTY

This county society was well represented at the Councilor District meeting in February, 1968 when we entertained senior pre-medical students from Juniata College and Penn State University at the Nittany Lion Inn, State College.

MIFFLIN — JUNIATA COUNTY

Mrs. Dale and I had the privilege of attending the

SEVENTH DISTRICT *Robert S. Sanford, M.D.*

During the past year it has been a pleasure for this Councilor to serve the seven counties of the Seventh Councilor District and the six county medical societies involved. The cooperation of these county societies and their members has been gratifying and it is a pleasure to report that there have been no major problems within the Councilor District throughout the year. There has been good representation and interest within county societies which has resulted in activity within the county structures and at the State Society level also.

The major part of the Seventh Councilor District is made up of an expanse of rural areas covered by minimal numbers of physicians for the population within the counties. This situation creates some of the major problems which constantly plague medical coverage of the counties represented. Even Lycoming County, the more urban portion of the District, has a decreasing number of general practitioners. This places added loads on the numerous specialists within that county. As general practitioners retire, die or move away for various reasons, replacements have been almost impossible to find. Such trends are increasing the load of patients on the current practitioners to a point of no return. These trends, therefore, become a major problem for all counties of the Seventh District to such a degree that this Councilor believes that the Pennsylvania Medical Society should cooperate through all means possible to aid the rural counties to acquire additional physicians.

The advent of Federal and State regional medical programs, regional planning organizations and other federal government projects is also creating problems within the Seventh Councilor District inasmuch as at least four of the component county societies are so-called "border counties" where affiliations with these large medical programs are apt to be in different directions to such an extent that eventually medical unity within the District may be broken. Tioga and Potter Counties are tentatively being affiliated with New York State programs and the Elk-Cameron Society is tentatively being affiliated with the Pittsburgh region. These disturbances of District unity should be thoroughly studied within the county societies and should be studied by the Pennsylvania Medical Society as they relate to the ease of communications and the quality of medical practice in the future, with emphasis on the further study of possible reorganization of Councilor Districts. The high quality of medical practice in the State

Annual Dinner-Dance of this active Society in January, 1968.

In December, 1967 I attended two long meetings of this Society when the resolution concerning the participation of these physicians in the Medical Assistance Program under Title XIX was prepared. In January, 1968 three members of this Society presented the resolution to the PMS Board of Trustees and I am proud to say that it was unanimously endorsed by the PMS Board.

I am proud to represent this district of approximately 300 members and always welcome calls from anyone about problems that may arise.

of Pennsylvania is in jeopardy under the influence of these previously discussed trends.

CLINTON

The Clinton County Society continues to show local activity and has excellent interest and representation in the functions of the Pennsylvania Medical Society. During the past year this County has held a measles vaccine clinic at the Lock Haven Hospital with gratifying response. The county officers are showing marked interest in maintaining an active, vigorous organization.

ELK - CAMERON

The Elk-Cameron County Society shows activity within its area and although this is a two county organization it has functioned well to aid all the communities in these counties. There has been representation at State level functions with endeavors to function in the larger Federal and State programs.

LYCOMING

This County Society continues to be the backbone of District functions. The participation of its members in County, State and American Medical Association activities is most gratifying. There is a continued interest in educational programs within the county and these programs are also made available to the surrounding county societies. Lycoming County had a very successful Measles Vaccine Clinic in April, 1968 with approximately 6,800 persons vaccinated.

POTTER

Potter County Medical Society, the smallest of the component societies of this district, had a Measles Vaccine Clinic with the members present at four clinic sites and continues to carry out active medical help for the annual influx of migrant workers into the county. The new Coudersport Hospital has added to this rural area a medical facility which was previously lacking. Unfortunately adequate staffing of the Hospital has been a problem to date, but this Councilor expresses encouragement in the continued growth of this type of medical facility and hopes that in the future this unit will function at maximum capacity.

TIOGA

The Tioga County Society had a Measles Vaccine Clinic in the spring with very satisfactory participation from Society members and the public. This County is one area which suffers from lack of adequate medical personnel. The members, however, are showing increasing interest in the programs of the Pennsylvania Medical Society and in the larger Federal and State Regional programs with special reference to maintaining their association with Pennsylvania Regional Programs.

UNION

The Union County Society shows continued interest in local county functions and, being the newest independent county society within the District, its problems of independence have been slow to materialize. However, there

EIGHTH DISTRICT *James A. Biggins, M.D.*

The following is a summary of the activities of the county societies comprising the Eighth Councilor District.

CRAWFORD

At the present time this county society has forty-nine active members, three associate members, and four retired members. One member left to enter government service in Guatemala recently. Five new members have been admitted to the society in the past year. One member, Edgar J. Werle, M.D., passed away.

The Crawford County Medical Society holds regular monthly meetings with a scientific speaker at each one, usually someone from a nearby university or specialists from larger surrounding towns. Every three months there is a meeting to which the wives are invited. One of these is formal, with corsages, evening gowns, orchestra, and the works.

We successfully completed a tetanus campaign last year, and although the society didn't sponsor the measles immunization clinics, our members staffed them and directed them.

Actually, our society has been very inactive from the standpoint of organized medicine. Several of the younger members have been trying to create interest in political and economic medicine and to encourage more active participation in organized medicine at the state level. This has met with limited success. The consensus of opinion seems to be to let matters be as they are, that any efforts on our part will not do anything to change things, that Medicare is here to stay, etc.

Several of the younger wives have made attempts in the past six months to reorganize the Woman's Auxiliary, and they have held several meetings in this connection.

We did manage to get our pathologist elected coroner in the last election, and it was a close one. It was a dead tie in votes, so the two winners appeared in the judge's quarters, and the winner was decided by the flip of a coin. Wilbur C. Thomas, M.D., our pathologist and President of the County Society, won the toss. He has been doing an excellent job since he took office.

ERIE

There are one hundred and ninety-seven active, three

has been participation in Pennsylvania Medical Society programs throughout the year.

In summary, this District Councilor has been well pleased with the general functions of all the component county societies of the Seventh Councilor District during the past year. Once again it would be well to call to the attention of the House of Delegates as well as the members of the component societies the increasing need for an "all out" effort on the part of the Pennsylvania Medical Society to aid the rural counties in obtaining more physicians. Such programs must start at the medical school level with increased emphasis on the continued need for general practitioners for the rural areas. The rewards are great, but the work is hard. Also, reemphasis is needed on the possibility of reorganization of councilor districts as influenced by the rapidly developing Federal and State medical programs based on a need for improved methods of communications.

temporary, one senior active, and three resident members of this Society. In addition Erie County has thirty associate members, one temporary associate member, and one affiliate member. Five new members joined during the year: Bernardino DiStefano, Manoucher Tavana, Jay L. Jenkins, Douglas C. Rist, and Robert Marsh. Three members expired during the past year: F. W. Underhill, James Stark, and W. C. F. Smith. One member is in military service: Juan Delgado.

Among the highlights of an extremely active year for Erie County are the following:

1. Establishment of a record fifteen Future Physician Clubs.
2. Hugh Allen's representation on Northwestern Pennsylvania Health Facilities Planning Council.
3. Awarding of approximately \$4,000.00 in scholarship grants from the Society's Sabin Scholarship Fund to fourteen students.
4. A successful measles vaccination program conducted on a county-wide basis.
5. Personal direction by R. O. Byers, M.D. of the Utilization and Review Committee on Nursing Home Care, including the required patient examinations and reports.
6. Initiation of the H.O.W.N.Y. (Health Organization of Western New York) program of educational services to health personnel. John Hartman, M.D., a member of the governing board, represents this area.
7. A concentrated effort to gain physician representation on hospital boards resulted in agreement by the hospitals to have three members of the Erie County Medical Society serving on the boards in a non-voting capacity.
8. Recommendation by the Society to County Commissioners to relinquish remaining isolated area of old county infirmary being used for TB patients so that chronically ill and indigent facilities can be expanded.
9. Anthony Merski, M.D. elected as third eligible member of House of Delegates after the Society's membership reached two hundred and one. New alternates are Daniel Snow, M.D., Richard Kuhn, M.D., and Thomas Miller, II, M.D.

10. Formation of special Legislative Committee, in accordance with theme of the recent Officers' Conference. This group will keep members up-to-date concerning legislative proposals and their ramifications and also keep legislative representatives apprised of members' opinions regarding these matters.
11. Two socio-economic and two scientific meetings of the membership were held during the year. Meetings of the Executive Board are held each month with the exception of July and August.
12. Dues remain at \$30.00 a year.

McKEAN

The McKean County Medical Society has been saddened by the death of four members this year: Dwight C. Hanna, Jr., M.D., Julius L. Waterman, M.D., Charles Luckett, M.D. and Michael E. McCarthy, M.D. Two new members have been added—Jafar Hamidi, M.D. and Anita Herbert, M.D. William C. Anderson, M.D. is serving as a missionary in Kenya for a two year term. This gives us a membership of twenty-eight, and although small, the Society is an active one, holding eight meetings a year. Six of these are dinner meetings with speakers, usually from Buffalo and Erie. At Christmas time there is an annual dinner dance with the McKean County Bar Association; in June there is a golf-dinner meeting.

This spring the Society presented a check for \$15,554 to the University of Pittsburgh, Bradford Center, to be used at the discretion of the University in its expansion program. This represented the money collected and interest accrued from Polio Sunday in 1953.

A county-wide measles immunization project was held May 26 in Kane, Smethport, Bradford and Port Allegany. A total of 615 children under six and 720 over six were given inoculations. This was considered very successful.

The Lutheran Nursing Home at Kane has become operable this year and meets a need of this county with forty available beds. Since we have lost so many members by death in the last few years we are urgently in need of a general practitioner in Kane.

MERCER

We have had a successful year with excellent programs. One of the highlights was the visit by Charles L. Hudson, M.D. in March.

Considerable discussion about utilization committees for extended care facilities took place. Physicians of the County Society had taken over this function successfully, but have since been replaced by the Blue Cross Review Committee from Allegheny County. There has also been much talk about hospital planning. There has been no purposeful action generated by our county society in this area. We assume that our membership is willing to help, but we neither know how to go about it or what to do.

A very successful measles immunization program was directed by the Mercer County Medical Society. Funds accumulated from the tetanus immunization program were turned over to the Pennsylvania Medical Society Educational and Scientific Trust to create a financial assistance program for those in need who are entering medical and health-related fields of study.

Our dues notices include the auxiliary dues and the price of meals for the members on an annual basis.

There has been continued effort during the year to effect physician representation on our three hospital boards with no response at the present time.

An advisory committee from the society has been appointed to consult with the Mercer County Commissioners in medical affairs which may arise in the county or in any matters pertaining to the Mercer County Institutional District.

We note with keen interest and sincere respect the warnings and predictions of informed medical and political leadership that we are in a health revolution. Except for some requests for restraint in fees, we still are pretty confused about what we can or should try to do about this in terms of our day to day practice of medicine.

CONCLUSION

Unfortunately at this time no report has been received from the Warren County Medical Society.

The Councilor for the Eighth District has not visited the county societies during the past year, but has regularly attended the meetings of the Board of Trustees. An effort has been made to keep in touch with the various societies through contact with individual members at other meetings. I wish to take this opportunity to thank the officers and members of the county medical societies in the Eighth Councilor District for their assistance and cooperation during the past year.

NINTH COUNCILOR DISTRICT *Cyrus B. Slease, M.D.*

The component societies of the Ninth Councilor District have had regular meetings during the past year. Four of the six counties have been visited since the last annual session. There have not been any major problems brought to my attention except the continuing shortage of physicians.

For several years I have pointed out the physician shortages that exist in this district. With increased paper work, increased demands from patients, and a decreased number of physicians in general practice, it becomes more and more difficult to find time to properly care for those people needing care.

The Comprehensive Health Planning Commission of

this area has scheduled a meeting for July 11, 1968, at Brookville, Pennsylvania. This meeting will include four counties of the Ninth District and two counties of the Seventh District. From these counties the following have been invited to attend this meeting: the presidents and secretaries of the county medical societies; hospital administrators; hospital board representatives; and certain lay individuals from the area including representatives of health organizations, e.g., the Tuberculosis Society and others. This will be an organized effort to evaluate already existing facilities and to plan what could be added in order to provide the greatest amount of care for the greatest number of people. Since it appears that we face

a gradual decrease in the number of physicians in general practice, and since modern techniques and procedures are not, in many cases, adaptable to use in the home or office, some other way has to be found to make these services available to more people. These new methods may lie in the development of out-patient clinics, regional treatment centers, or some other facility. This proposed meeting deserves the attention and cooperation of every-

one in the area, and I strongly recommend that physicians aid in the Comprehensive Health Planning programs to the best of their ability.

The Woman's Auxiliaries in this Councilor District have been very active. The District Review Committee has not been called upon this year to date.

I wish to take this opportunity to extend my thanks to the members of the Ninth District for their cooperation.

TENTH DISTRICT *William J. Kelly, M.D.*

The following is a summary of the activities of the four county societies comprising the Tenth Councilor District:

ALLEGHENY

The 1968 year has been a very active one for the Allegheny County Medical Society. As in the past, the following have been an integral part of this Society's activities:

- Training of police and firemen
- Participation in School Science Fair
- Speaking engagements on medical and related topics
- TV appearances and programs sponsored by its members
- Co-sponsoring Health-O-Ramas
- Providing personnel to man the first aid booth at the County Fair
- Comprehensive health planning
- Liaison with the Hospital Council of Western Pennsylvania and the Hospital Planning Association
- The Allegheny County Medical Society Foundation
- The Hospital Utilization Project
- Blue Cross Review Committee
- Medical Care Co-ordinating Committee
- Grievance Committee review and disposition of numerous complaints
- By-laws changed to be more in accord with State Society Constitution and By-laws
- Child Health Care
- Liaison with the University Health Center
- Utilization Review Committee

In addition, several changes have occurred in Allegheny County. The Society has employed a new Executive Secretary and procured an assistant for him to aid in the Medical Service area. The Board of Directors held a well-attended Testimonial Dinner for Mr. Fred Fagler, their retiring Executive Secretary. High praise and abounding tribute was paid from all corners of this state for his accomplishments for medicine, his devotion to our profession, and for his many years of service. This Councilor, this State and this Society are forever indebted to this capable organizer and friend of medicine.

The Allegheny County Medical Society has purchased and cleared land for a new headquarters building and should be starting construction soon.

A complete reorganization of the branch structure of this society is under way. The new structure will include eight branch organizations. The quarterly scientific sessions have been discontinued temporarily in order to try the branch organization approach to improve attendance and participation in organized medicine activities.

A complete reorganization of emergency medical care

is being studied and developed by the Allegheny County Medical Society in cooperation with the city planners, hospital authorities, police, firemen and other interested parties. Another annual medical-legal conference was held. The outcome was approval of a medical-legal inter-professional code. This code was prepared to assist physicians and attorneys in better understanding their respective duties to each other and to the patient-client. New members' dinners and orientation courses have continued to be well attended. This county was also active and aggressive in advocating approval of the proposals of the Constitutional Convention.

In the Medical Service area the Allegheny County Medical Society has been most active and has appointed a committee to aid in providing additional medical care in the Lower Hill area of Pittsburgh. Representatives of the Society have met with Model Cities personnel to discuss their problems. Chairmen of the Society's various committees have met with the Council of the Western Pennsylvania Regional Medical Program and made recommendations to the Program. The local staff committee, including physicians, has met with the Comprehensive Health Planning Group to prepare an application for a health grant under Public Law 89-749. Sex education in the schools and how it should be taught has been considered this past year. There has been repeated contact and discussion with the Health and Welfare Association of Allegheny County concerning health programs. In addition, there has been close contact with County Commissioner William Hunt, M.D. and the County Coroner, Ralph Stalter, M.D., both very active members of the Society.

One of the changes in Allegheny County was the Board's decision to discontinue the policy of having the Pennsylvania Medical Society do the Society's dues billing.

"Voice of Medicine" certificates were presented to three members of the Allegheny County Medical Society. It is planned also to honor appropriately the three members of this Society who served in the Volunteer Physicians for Vietnam Program.

BEAVER

The Beaver County Medical Society reports a total membership of 154, of which 146 are active and eight are associate members.

A great number of its physicians took part in programs on health problems of grade school children and sex education at the high school level.

Fifteen physicians in Beaver County assisted in the public education effort of the Cancer Society during this past year. A total of forty-five clubs, organizations and schools had the benefit of a physician speaker.

The Annual Dinner-Dance was held at the Beaver Valley Country Club on October 14, 1967.

On December 28, 1967, the Beaver County Medical Society entertained all medical students residing in Beaver County who are attending medical schools or who have been enrolled in such a school. It is the aim of this Society to become acquainted with these students and explain the policies of the Society in the hope that many of these students will return to Beaver County to practice medicine.

Beaver County's third Health-O-Rama was completed at the Central Elementary School in Beaver Falls. Although the attendance was not as large as had been hoped for, nearly 16,000 free health screening tests were provided.

There has been continued interest in scientific meetings and a medicine and religion program is being planned for the fall. Also planned are the presentation of a plaque to Eugene F. Berkman, M.D., for his service in the Volunteer Physicians for Vietnam Program and a Voice of Medicine award for Alfred E. Chadwick, M.D. During the past year County Society Headquarters has been moved to a new location in the Federal Title and Trust Building in Beaver Falls.

LAWRENCE

The Lawrence County Medical Society has continued to be active locally with routine Board meetings and interest in the local community health. To this end the Lawrence County Medical Society initiated and conducted a successful tetanus immunization program for its citizens this past year. In addition, there has been an attempt to change the By-laws in order to bring them into accord with the State Society Constitution and By-laws and to change the terms of delegates to the PMS House of Delegates.

Local inconveniences have revolved around the strike of radiological technicians at one hospital which has delayed construction at another hospital. The Society has adequately solved the surgical assistants' fee problem to the satisfaction of its members. There has been some concern with the invasion of the practice of medicine locally by non-physician practitioners and the referral of

patients outside the cities of New Castle and New Wilmington for further care.

Osteopathic association with local hospitals has been considered this past year. Hospital planning principles have also been discussed and considered during the year.

Problem cases are being reviewed as necessary by local physicians in committee.

WESTMORELAND

This Society has continued to be active at a local level and this past year has devoted most of its efforts to the County Mental Health program and clinics. The physicians of this county are to be commended for their participation in meetings to help get this program working properly, for their cooperation in making referrals and for their continued interest in patients that have been referred to the Mental Health Clinic.

The County Society has continued to make available to its members scientific programs for their continuing education. The grievance committee has continued to resolve complaints satisfactorily. Membership categories have been changed to comply with the State Constitution and By-laws. A Westmoreland County Medical Society Scholarship program has been added to the Society's activities.

The county society office has purchased a new mimeograph machine and is concerning itself with the establishment of a multiphasic diagnostic screening center.

CONCLUSION

In summary, I would like to report to the House of Delegates that I have continued to supply each component society in my District with summaries of the important actions of the Board of Trustees of the State Medical Society. In addition, I have had contact with each society and have been in attendance at some of their board meetings. I have requested the county societies to apprise me of any problems in which the State Society may be of help to them.

Your councilor has considered it a privilege to serve the members of his District and promises to keep the component societies aware of all activities at the state level.

ELEVENTH COUNCILOR DISTRICT *D. George Bloom, M.D.*

The Eleventh Councilor District has had an active year which began with a Councilor District meeting last September, held in conjunction with the 1967 Annual Session. At this meeting your Trustee and Councilor informed those present that he was willing to attend any county medical society meeting to which he was invited and that he would provide district component societies with any reports which they requested. Component societies were also encouraged to submit the names of members who would be interested in serving on State Society councils and committees. Other discussion at the meeting related to fee billing under Medicare and the formation of area and community committees for comprehensive health planning. Several resolutions and reports to be considered by the House of Delegates were also discussed.

Activities in which this Trustee and other members from many parts of the District participated during the 1967-68 year include the conference on Comprehensive Health Planning held in Pittsburgh in November and the Regional Medical planning meeting held in Altoona in February. These meetings led to increased participation in area planning activities by the county societies in the Eleventh District.

The District Board of Censors has considered no new cases, but one case was adjudicated. Several cases have been brought to the attention of the Medical Care Coordinating Committee and these are currently being reviewed.

Individual component societies in the District also had a busy and productive year during 1967-68. Summaries of the reports of several individual counties follow below:

CAMBRIA COUNTY

In 1967, the Cambria County Medical Society made some progress in the area of comprehensive health planning. After a series of meetings, a steering committee of interested persons in Cambria County was appointed whose duty it is to select a permanent advisory committee. This steering committee was selected at a meeting called for December 4, 1967 by the Cambria County Medical Society Committee for Areawide Planning for Community Health Facilities. Approximately 100 community leaders attended. It is anticipated that a permanent committee will be selected soon. County Society representation on the committee is assured.

In addition to the Society's local efforts to establish a planning committee, the Society was represented at a number of other meetings held throughout the state for educational purposes on community health planning.

Also in 1967, the county society completed a study for the revision of the constitution and by-laws. Recommendations made by the study committee were approved in early 1968. New copies of the By-laws were distributed early this summer.

A Diabetes Detection Program was held in Johnstown May 21, 1968, in cooperation with the Pennsylvania Department of Health. In addition to the above, Cambria County held its usual programs of scientific discussions and routine business. Fewer than six grievances were referred to the Grievance Committee.

SOMERSET COUNTY

The Somerset County Medical Society held a Measles Vaccination Program in association with the Pennsylvania State Department of Health in October, 1967. The Society is represented on the Western Pennsylvania Regional Comprehensive Health Planning Committee by William C. Ryan, M.D.

In connection with the Western Pennsylvania Regional Medical Program we are in favor of continued representation from smaller rural counties and the inclusion of these areas in the formation of policies and programs. We wish to take this opportunity to make two recommendations in connection with the Western Regional Medical Program:

1. That a survey of physicians be taken in order to determine the most convenient time for programs.
2. That better advance information of meetings be provided physicians so that they may plan their schedules accordingly.

TWELFTH COUNCILOR DISTRICT *Park M. Horton, M.D.*

LUZERNE COUNTY

The Luzerne County Medical Society has 338 members: 269 active, forty-three associates, eight residents, eleven senior active, three affiliates and four honorary affiliates. It is comprised of the parent society with its offices in the Luzerne County Medical Society Building in Wilkes Barre

WASHINGTON COUNTY

In June of 1967 members were urged to write to State legislators to halt the inclusion of chiropractic services under Medicare. In December of 1967 members were urged to write State legislators concerning the adoption of a Medical Examiner System. Just recently letters were written to our State Senators urging them to vote against inclusion of chiropractors in the "Pennsycare Bill."

Members of the County Medical Society assisted in a Measles Vaccine Immunization program conducted under the auspices of the Pennsylvania Department of Health. A total of 3,870 children were vaccinated in fourteen clinics set up throughout the county. In addition a Diabetes Detection program was held in Washington in April of 1968. It was sponsored by Pennsylvania Department of Health, with members of the County Medical Society participating.

Members participated in prenatal classes sponsored by the Y.W.C.A. during the first part of 1968. A Heart Symposium co-sponsored by the County Medical Society and the Southwestern Heart Association meeting was held in April of 1968. The County Medical Society also cooperated with the Pennsylvania Department of Health in a Venereal Disease Workshop in September, 1967. Joseph McMahan, M.D., one of our members, supervised an Ambulance Attendants Training Course in Washington during the first part of 1968. E. L. Abernathy, M.D., another member, delivered innumerable speeches on smoking under the auspices of the American Cancer Society.

During the 1967-68 year we gained five new members. Three members were lost by death, four by transfer to other counties, and two members moved out of the State.

CONCLUSION

The Fayette County Medical Society Committee on Medicine and Religion sponsored a joint meeting with the clergy on the subject *Death with Dignity* in the form of a panel program, Thursday, March 7, 1968, at the Uniontown Hospital. Unfortunately I was unable to attend this meeting as I was attending a meeting of the State Board of Medical Education and Licensure in Harrisburg. The Bedford County Medical Society awarded its Benjamin Rush Award to LeGrand W. Perce, III.

Several county societies haven't submitted reports to me, but from all indications the work of these societies has been proceeding smoothly and no problems of a unique or difficult nature have been brought to my attention. My second year as Trustee and Councilor for the Eleventh District has been an absorbing one and I have appreciated this opportunity to serve.

with Mrs. Leona O. Franey, Executive Secretary, and the Hazleton Branch of the Luzerne County Medical Society. The Society has a Professional Services Bureau housed in the Society building which provides a telephone answering service, collection services and credit reference files. Both branches of the Society hold regular business and scientific meetings and provide excellent service to their members.

This Society publishes *The Bulletin* monthly. This is an outstanding publication and Editor Edward R. Janjigian, M.D. is to be congratulated for his excellent work and exceptional editorials which appear in each issue. It is hoped that each member of the Society looks forward to reading these articles with as much anticipation as this Councilor.

The Annual Meeting of the Luzerne County Medical Society was held at the Westmoreland Club in Wilkes Barre on January 20, 1968. At this meeting the Society's Annual Benjamin Rush Award was presented to Miss Arline Phillips of the Pennsylvania Association for the Blind and the Group Award was presented to the Georgetown Settlement House. E. R. Janjigian, M.D. was presented a plaque for fifty years of service. James Z. Appel, M.D. gave an address, *Who Speaks For Medicine?* Jacob G. Hyman, M.D., retiring President, installed Russell A. Stevens, M.D. as the new President. The Woman's Auxiliary, with Mrs. William R. A. Boben as President, is very active and holds interesting programs and renders many services to the Society and the community.

BRADFORD COUNTY

The Bradford County Medical Society has fifty-seven active members, two associate members, and three temporary members. This society, with Henry Lively, M.D. as President and Ralph B. Winston, M.D. as Secretary, has had excellent scientific meetings each month with a fairly good attendance. In November, 1967, the Society sponsored a Cancer Seminar with an outstanding faculty. In December, 1967, this Society held a joint meeting with the Bradford County Bar Association and the Medical and Bar Associations of Tioga County, New York. At its annual meeting held in May, 1968, William C. Beck, M.D. was elected President, succeeding Henry S. Lively, M.D., and James McQuillen, M.D. was elected Secretary to succeed Ralph B. Winston, M.D. As it has for years, The Guthrie Clinic and Robert Packer Hospital, Sayre, continues to grow and develop as a multi-specialty group. This group serves both as a training institution and as a modality for the delivery of medical service to a large area in Pennsylvania and New York State. The Annual Reunion of the Internes and Residents of the Guthrie Clinic was held in May with Milford O. Rouse, M.D., Immediate Past-President of the AMA, delivering the Donald Guthrie Memorial Lecture. The Woman's Auxiliary of the Bradford County Society meet concurrently. The Auxiliary is active in support of the Society's programs and community projects.

WYOMING COUNTY

The Wyoming County Medical Society has eleven active members and holds regular meetings. The Tyler Memorial Hospital serves as the center of medical service in this county. During the past year the hospital established an emergency room service which has greatly improved its medical service to the community. J. S. Rinehimer, Jr., M.D. became President of the Wyoming County Society at its annual meeting, succeeding Helen M. Beck, M.D. C. J. H. Kraft, M.D. continues as Secretary. Doctor Kraft is Chairman of the Commission on Rural Health

of the PMS and has recently been reappointed a member of the Council on Rural Health of the AMA.

SUSQUEHANNA COUNTY

The Susquehanna County Medical Society has twelve members. James Miller, M.D. succeeded James McClure, M.D. as President at the annual meeting and Michael Markarian, M.D. continues as Secretary. This Society held another Teaching Day, with the faculty provided by the Educational and Scientific Trust of the PMS. The Society also initiated a training program for the Volunteer Ambulance Group of the County with the members of the Society as instructors. The Montrose General Hospital, Montrose, and the Simon H. Barnes Community Hospital, Susquehanna, serve as the centers for the delivery of medical service in the county. There is one approved extended care facility in Montrose and plans have recently been approved for the construction of a second one in Susquehanna.

OTHER EVENTS AND CONCLUSION

A Twelfth Councilor District Meeting was held September 27, 1967, in the Crystal Room of the Bellevue-Stratford Hotel, Philadelphia. Representatives of each county society reported on their current activities. Mr. Richard Sloan of the PMS staff presented a proposal for the establishment of a Twelfth Councilor District Medical Advisory Committee to Blue Cross of Northeastern Pennsylvania. This proposal was later presented to all county medical societies of the District and approved by all except the Bradford County Medical Society. Subsequently all hospitals were contacted and requested to appoint staff members to serve on this Advisory Committee. It is expected that in the near future a meeting of this entire committee can be held to plan its future course and activities.

Since the Twelfth Councilor District falls within the geographic areas of three Regional Medical Programs (Susquehanna Valley R.M.P., Greater Delaware Valley R.M.P., and Central New York R.M.P.) it becomes imperative that more physicians become involved in the planning stage of these regional programs. In addition, the Comprehensive Health Facility planning programs and the City and County Planning Commissions will require more participation by the physicians of the District.

It is hoped that in the near future more young physicians may be persuaded to start partnerships or small group practices in the rural areas where older solo practitioners have provided medical care in the past.

This trustee has attended all meetings of the Board of Trustees during the past year. He has served as Chairman of the Finance Committee, and as a member of: (1) the Advisory Committee to the Executive Director; (2) the Special Board Committee to the Susquehanna Valley R.M.P.; (3) the Medical Benevolence Committee; (4) the Committee to study the Medical Defense Fund; (5) the Committee to study the Format and Timing of the Annual Session; (6) the Officers Conference Committee; and (7) the Committee on Convention Program. He is a Trustee of the Educational and Scientific Trust. He has also served as a Delegate to the AMA, attending the meetings in Houston and San Francisco.

SUMMARY REPORTS OF STANDING COMMITTEES

COMMITTEE ON AID TO EDUCATION

The loan and scholarship programs of the Educational Fund, together with the other student aid programs of the Educational and Scientific Trust, assisted 216 students with scholarships and loans of \$141,852 during the 1967-68 school year. Of these students, 155 were in medical school with the help of loan and scholarship assistance amounting to \$109,717.

Sixty-seven medical students graduating in 1968 received \$118,957 while in medical school. Forty of these students are interning in Pennsylvania hospitals.

The revised medical school scholarship program went into effect with the 1967-68 school year when 11 first-year students received one-year, full-tuition scholarships and 21 upperclassmen received half-tuition scholarships with a total value of \$24,270.

The Committee on Aid to Education recommends that \$8.00 again be allocated from the 1969 annual assessment for the Educational and Scientific Trust to support this worthwhile loan and scholarship program.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Committee acted in an advisory capacity whenever called upon by the Woman's Auxiliary regarding its functions and changes in its By-laws. One formal meeting was held during this year, and, when necessary, a mail vote was taken to seek the guidance of the Committee.

Auxiliary members continued to support the American Medical Association Education and Research Foundation, the Educational Fund of the Educational and Scientific Trust, and the Medical Benevolence Fund. Contributions to the aforementioned funds totaled \$20,967.74 for the twelve-month period, June 1, 1967, to May 31, 1968.

As the interest and concern for health manpower increased, the county auxiliaries presented sixty-two scholarships and loans, totaling \$17,073. In addition, many counties planned a day for health careers and fairs for the purpose of acquainting the public with the needs and opportunities currently existing.

Ever remembering foreign friends, component auxiliaries, through their international health activities, sent a total of 19,677 pounds of pharmaceuticals overseas. In addition, the State Auxiliary served as the official hostess to Miss Kyoung Sook Suk of Korea. While in Pennsylvania studying rehabilitation for the blind, physicians' wives welcomed her into their homes.

Members of the State Auxiliary were actively involved in numerous community service activities. Many members provided assistance during the immunization programs.

The Committee wishes to recognize the interest demonstrated in the legislative activities of the Pennsylvania

Medical Society expressed by auxiliary members writing "Letters to Legislators."

In order to establish a rapport with wives of medical students, interns, and residents, the Auxiliary appointed a State Liaison to the Woman's Auxiliary to the Student American Medical Association.

Recognizing the importance of communications and keeping the officers and chairmen well informed, a NOTE-WORTHY COMMUNIQUE newsletter was instituted to provide up-to-date information and directives to the state and county auxiliary leaders between issues of the official publication, *Keystone News*.

Another important activity of the Auxiliary was the annual Mid-Year Conference held in April which was well attended and provided an excellent opportunity for members to learn more about the programs and exchange ideas.

The Committee proudly reports that the Woman's Auxiliary to the Crawford County Medical Society was organized on March 20, 1968, making a total of fifty-seven organized component auxiliaries.

The Auxiliary membership as of May 1, 1968, was 5,611 members including thirty-five members-at-large.

Last year thirteen counties implemented the resolution regarding "Voluntary Joint Billing" that was adopted by the 1966 House of Delegates of the Pennsylvania Medical Society. This year the Committee is pleased to report that a total of twenty-five counties are including Auxiliary membership on their dues statements which reflects an increase of twelve counties implementing this resolution.

REPORT OF THE COMMITTEE TO STUDY RELATIONS BETWEEN MEDICINE AND OSTEOPATHY

The Committee on Relationships with Allied Professions has reported a very active year which included several meetings and the first Physician/Nurse Seminar entitled *Patient Needs in Pennsylvania*, which was held at the Society's headquarters building on January 11, 1968. The Seminar was jointly sponsored by the Society, the Pennsylvania League for Nursing and the Pennsylvania Nurses Association. The Committee reports that the principal

purpose of the Seminar was to begin a dialogue with the nursing groups on matters which included "the shortage of nurses, better utilization of existing nursing personnel, the educational programs and the nurse/physician relationship at both the state and local levels." The Committee reports further that it plans to bring the results of this first Seminar to the county and regional levels by sponsoring five regional meetings to be held at key geo-

graphical locations throughout the State, all on October 8, 1968. The locations will be Philadelphia, Pittsburgh, Erie, Scranton and Altoona. It is the Committee's feeling

that if the agreements reached at the first Seminar are to be carried out successfully, they now must be considered and discussed at regional level.

COMMITTEE ON CONVENTION PROGRAM

The following significant actions were taken by the Committee on Convention Program during the past year:

Conducted a thorough evaluation of the 1967 scientific sessions which showed that concentrated, in-depth programs are acceptable and that the seminar for nurses and paramedical personnel was the most popular feature of the sessions.

Selected the site and dates for the 1969 scientific sessions and started work on the course content.

Developed a program for the 1968 scientific sessions with the theme *Electrolyte Metabolism and Renal Dis-*

eases. Supplemental programs include: (1) a seminar for nurses and paramedical personnel on renal diseases; (2) evening sessions on *Group Practice* and *The Status of Organ Transplantation*; and (3) scientific and/or board meetings of eleven of the statewide specialty organizations.

Endorsed action of the 1967 House of Delegates to permit separation of business and scientific sessions.

Endorsed recommendation of Board of Trustees and Councilors to establish a Council on Education which would replace this Committee and the Commission on Medical Education.

COMMITTEE ON MEDICAL BENEVOLENCE

The Committee on Medical Benevolence expended \$43,060 in 1967 in providing assistance to nine physician members, six wives, eighteen widows, and eighteen children. Comprising twenty-eight family units, these recipients received this aid upon the recommendation of twenty county medical societies after investigation of the extent of the financial distress by a member of the county medical

society who served as sponsor.

Contributions of over \$9,000 were received during the year, largely from the Woman's Auxiliaries to the county medical societies.

It is the recommendation of the Committee that the allotment from the annual assessment in 1969 again be set at \$1.00 per active member.

COMMITTEE ON OBJECTIVES

The Society's By-laws stipulate that it shall be the duty of the Committee on Objectives "... to recommend objectives to the Board of Trustees and Councilors and to the House of Delegates, and to review annually these objectives and recommend any desirable changes." During the course of the 1967-68 year the Committee has examined the Society's orientation toward various problems and reviewed several facets of the Society's program in order to fulfill this important task with which it has been charged. Of necessity the Committee's discussions periodically assume an abstract and philosophical nature; at other times they are very concrete. In all instances the Committee's goal is to ensure that the Society remains current in its thinking and realistic in its response to today's problems.

The Committee met four times during the past year. The various subjects of its deliberations are briefly summarized below.

REFERRAL FROM THE HOUSE OF DELEGATES

The Committee considered a referral from the House of Delegates which requested that the Committee study methods by which "primary contact" physicians could be included in plans for comprehensive medical care being currently implemented by medical schools. After considerable research into the background of this recommendation the Committee learned that it was intended primarily as a statement of purpose. The Committee concurs with this

goal and determined to keep the intent of the House of Delegates foremost in any future deliberations related to this subject.

LIMITATION OF MAXIMUM CONTINUOUS SERVICE PERMISSIBLE FOR DELEGATES

Dr. Harris recommended to the 1967 House of Delegates that the maximum continuous tenure of members of the PMS House of Delegates, members of the delegation to the A.M.A. and members of councils, committees and commissions be limited. The House of Delegates referred this matter to the Committee on Objectives for further study. The Committee met with Dr. Harris and he explained that the main thrust of his recommendation was aimed at members of the PMS House of Delegates since the terms of council and commission members were already limited. He indicated that it could also apply to the members of the delegation to the A.M.A. Dr. Harris suggested a limitation of twelve to fifteen years of continuous service. The Committee agreed with Dr. Harris that his suggested limitation would allow sufficient service for the most dedicated souls while at the same time providing a minimum safeguard against abuse. For this reason the Committee adopted Dr. Harris' recommendation and reported its approval to the Board of Trustees. Since that time the Board of Trustees has referred this matter to the Committee on Constitution and By-laws so that it might draft appropriate amendments to implement this recommendation.

COUNTY SOCIETY ORGANIZATION

At the 1967 Annual Session Dr. McClenahan recommended that a study be made to ascertain whether it would be possible for several small county medical societies to cooperate in the hiring of staff so that communications (in the broadest sense of the word) with the physicians of the area might be improved. This recommendation was referred to the Committee on Objectives.

The Committee on Objectives delegated a subcommittee to consider this matter. This subcommittee held an exploratory meeting with a pilot group of several county societies in order to ascertain whether there was any interest in cooperation of this kind. The subcommittee found a general recognition of the communications problem which prompted Dr. McClenahan's suggestion. This was exemplified by descriptions of the one-man operation of a small county medical society, in which communications are dependent upon the interest and energy of the county society secretary, and by the general admission that committees at the county society level are characteristically paper structures, which do not really function as committees.

However the subcommittee learned that there was little interest among these county societies in the kind of cooperation outlined in Dr. McClenahan's recommendation. The Committee on Objectives subsequently concluded that there is insufficient interest among county societies to pursue Dr. McClenahan's approach to this problem any further at the present time.

The conclusion was reported to the Board of Trustees. However, the Committee also pointed out to the Board that several of the county society representatives at the meeting expressed interest in the possibility that councilor districts be realigned on the basis of natural medical service regions, so that consideration might be given to the establishment of "district societies." These "district societies," it was suggested, might be staffed by state society executives. One approach to testing this concept considered by the Committee was the possibility of establishing a pilot "district society" which might include several interested counties. Because of these considerations the Committee recommended to the Board of Trustees that the desirability of the reorganization of councilor districts as a step toward attaining the objective of improved communications be explored in greater depth. At its meeting in May the Board of Trustees approved this recommendation and designated the Committee on Objectives as the unit to study this matter. The Committee will begin consideration of this referral at its forthcoming meeting in July.

COMMITTEE ON CONSTITUTION AND BY-LAWS

The Committee held a telephone conference in April to discuss a referral from the Board of Trustees upon which the Board requested an advisory opinion. The Committee also met in May to consider referrals from the 1967 House of Delegates and the Board of Trustees, as well as to discuss several other matters of business. The important decisions and work of the Committee during the past year are summarized below:

Prepared amendments to provide that the Speaker and Vice-Speaker of the House of Delegates serve as ex-

THE DELIVERY OF MEDICAL SERVICES

The primary subject of the Committee's deliberations during the year was the topic "The Delivery of Medical Services." The Committee's decision to consider this topic stemmed from its realization that there will be marked changes in all aspects of medical care delivery over the next fifteen to twenty years. It is the hope of Committee members that this study will ultimately help the Society to anticipate these changes and prepare for them. The Committee has had three very productive meetings on this subject and conferred with several consultants who contributed substantially to the deliberations.

Also in connection with the consideration of this topic several committee members attended the 1968 Officers' Conference. One point which was consistently stressed by the speakers at the conference was the necessity for physicians to become active in the implementation of federally financed legislation such as the Regional Medical Programs (P.L. 89-239) and the Comprehensive Health Planning Program (P.L. 89-749). The Committee concurs that it is imperative that practicing physicians become involved in the implementation of this legislation, and urges Society members to participate and cooperate in the planning for these programs at the local level.

It is apparent to Committee members, however, that most private practitioners are not familiar with the processes of planning for comprehensive health care. Specifically, we refer to the processes of organizing, setting goals, establishing priorities, etc., for these necessitate familiarity with management techniques. For this reason the Committee recommends that the Board of Trustees consider the possibility of sponsoring a course in planning, with the particular purpose of strengthening the representation of organized medicine in the regional medical programs and comprehensive health planning activities. Such a course should involve physicians who are participating in the implementation of these programs. An effective course could be expected to last approximately three days. A registration fee might be charged to offset the cost of the course.

At the present time the Committee has not summarized the results of its study on "The Delivery of Medical Care." The Committee plans a final meeting on this topic in July, and will prepare a supplemental report if specific recommendations are to be made. Consideration is being given to publishing a summary of this study for the information of the members of the Society.

officio members of the Board of Trustees with the right to vote and to stipulate explicitly that the Speaker and Vice-Speaker shall preside over meetings of the House of Delegates. These amendments were requested by the House of Delegates.

Prepared amendments to separate the annual business session of the House of Delegates and the scientific sessions in order to bring the Constitution and By-laws into accord with Society policy.

Prepared amendments to establish a Council on Edu-

cation under which all the Society's educational activities would be consolidated; these amendments were requested by the Board of Trustees.

Determined *not* to recommend amendments to establish limitations upon the maximum continuous tenure permitted delegates to the PMS House of Delegates and members of the delegation to the A.M.A.

Prepared amendments to provide a reminder to the House of Delegates to consider appropriate effective dates when considering amendments to the Constitution and By-laws in the future. The suggestion which resulted in these proposed amendments was made by the Chairman of the Board of Trustees as a result of difficulty encountered by several county medical societies in adjusting to

the extensive membership amendments adopted by the House of Delegates in 1967.

Prepared amendments to indicate explicitly the right of Society members to appear before reference committees. This proposed amendment was drafted upon the suggestion of the Chairman of the Committee on Constitution and By-laws and is also intended to remind each Society member that he has the responsibility to appear before a reference committee if he has information to which the Committee may not have access which will aid the members in their deliberations.

Published a revised edition of the PMS *Charter, Constitution and By-laws*.

COMMITTEE ON DISCIPLINE

The Committee on Discipline did not find it necessary to hold any formal meetings as of the writing of this report. Matters of discipline referred to the Committee were considered and acted upon by mail.

Liaison continued between the Committee on Discipline and the State Board of Medical Education and Licensure during the past year. Cases referred to the Committee by the State Board have been resolved to the satisfaction of both parties.

The Committee continued to offer the services of its members to county medical societies for the discussion and handling of disciplinary problems and other matters

of mutual interest. However, since our last report to the House of Delegates, there have been no requests made of the Committee.

The relatively inactive year of the Committee on Discipline is not due to any lack of interest on the part of its members. Evidently, complaints concerning the conduct of physicians have been handled quite satisfactorily on the local level and have not come to the attention of this Committee. However, this Committee would like to reemphasize to the House of Delegates that it stands ready to assist the State Board of Medical Education and Licensure and the state and county societies in discussing and investigating matters of discipline.

SUMMARY REPORTS OF SPECIAL COMMITTEES

REPORT OF THE COMMITTEE ON RELATIONSHIPS WITH ALLIED PROFESSIONS

The Committee to Study Relations Between Medicine and Osteopathy recites the past actions of the House of Delegates of both the American Medical Association and the Pennsylvania Medical Society, and the Committee's feeling that the problem is a national problem and not one necessarily of a local nature. The Committee makes a report based on the activities of the American Medical Association's Committee on Osteopathy in which it would

appear that cooperative action between Medicine and Osteopathy is imperative if any solutions are to be reached.

The Committee reports that so far activity in this area has been almost exclusively initiated by Medicine, and that so far the Osteopathic leadership does not seem to be overly enthused about further conversations, and until bilateral cooperation is evidenced, there is very little further that Medicine's Committees can do.

COMMITTEE ON MEDICINE AND RELIGION

The Medicine and Religion Committee of the State of Pennsylvania has endeavored to promote improved cooperation between physicians and clergymen in an effort to accomplish better total patient care. To accomplish this aim the Committee has encouraged programming at the state medical society level, the county medical society level and the community hospital level. It is contemplated that at some future time curriculum material for the accomplishment of this purpose will be presented to the

medical schools of this state to improve the cognizance of the student regarding its importance. At the recommendation of the National Committee, a state workshop will be conducted in the Fall of 1968 and 1969 to promote the progress of the effort. The clergyman and physician of today are serving a troubled society, and only by cooperating can we fulfill with integrity our reputations as the helping professions.

COMMITTEE ON GENERAL PRACTICE

This special Committee has established a position in regards to group practice. It is as follows:

"The Committee is anxious to point out that it does not endorse nor recommend group practice in lieu of solo practice of medicine. It is recognized that some physicians may find it more realistic to practice alone. But, in the future, the group practice of medicine may be a saving factor in regard to maintaining a free practice of medicine and, therefore, the Committee wishes to encourage those physicians who find it desirable to consider the group practice of medicine, whether in a single or multispecialty association."

Survey data was gathered about group practice in Pennsylvania as of April, 1967. It revealed that 128 single specialty groups and twenty-six multispecialty groups exist encompassing approximately 750 different physicians. Physicians inquiring to the information center maintained in the Society office about group practices are referred to single specialty or multispecialty groups within their locality. It has been found the best consultants to physicians forming groups are those who are already members of existing associations.

A special Sunday evening program on group practice will be presented on October 27 at the 1968 Scientific Session in Pittsburgh for students, interns, residents, and member physicians.

In regard to the limited availability of general prac-

tioners, the Committee makes the following recommendations on how to make services that they render more effective.

- Greater use should be made of paramedical personnel and further training should be instituted for paramedical personnel.
- Consideration should be given to the development of the assistant doctor concept.
- More encouragement should be given to the group practice concept since group practice will make physicians available for those procedures in which they are most competent and capable of doing and makes provisions for referring other procedures to paramedical personnel.
- All physician members of the Society are encouraged to participate in the regional medical and the comprehensive health planning programs.

The Committee recommends a new approach in the teaching curriculum of medical schools to help encourage the interest of students in general practice.

The Committee further recommends that a pilot study be undertaken in Central Pennsylvania with the regional medical program for a neighborhood health center to demonstrate satellite operations and rendering of medical care in which the "crossroad clinic type" approach could be used.

SUMMARY REPORTS OF ADMINISTRATIVE COUNCILS

REPORT OF THE COUNCIL ON GOVERNMENTAL RELATIONS

The Council on Governmental Relations reports that it has held a series of meetings since the last meeting of the House of Delegates to continue its progress on programs suggested by the House of Delegates and the Board of Trustees, as well as to initiate other programs which, in its opinion, are necessary to its mission.

The Council reports that because of the new two-year sessions of the State Legislature, authorized by a constitutional amendment at the 1967 Primary, the bills of interest to Medicine are on the increase. The Council also reports that since the last meeting of the House of Delegates they were active at the Constitutional Convention for the elimination of the "coroner" as a Constitutional officer. The Council reports that this language has been removed from the Constitution thereby paving the way for either a statewide or county-by-county Medical Examiner system.

The Council further reports on those resolutions referred to it at the last meeting of the House of Delegates, and, in all cases, the Council has taken some specific action.

Throughout the report it is apparent that the Council is concerned about the amount of legislative contact done by individual members of the Pennsylvania Medical Society. In their report they tell of efforts by the members of the Pennsylvania Medical Society's Woman's Auxiliary to help correct this problem. To the same end the Council reports that it initiated and conducted a successful Congressional visitation to Washington, D. C., in which it involved some thirty members of the State Medical Society and their Congressmen. The Council also arranged for a luncheon with the Congressmen following the visit by individuals to their offices. They are hopeful that this will be an annual affair.

The Council reports that since the State Legislature and Congress are still in session, that they are unable to give a final report on the over 150 measures in which they have an interest pending before the Legislature and the Congress.

COUNCIL ON MEDICAL SERVICE

The following report is intended to summarize the more significant activities of the Council on Medical Service during the past year.

The Council:

Continued to assist and advise Pennsylvania Blue Shield in the development and expansion of programs using the Prevailing Fee Plan.

Provided continuing consultation to Pennsylvania Blue Shield with respect to its role as intermediary for Part B, Title XVIII of the Medicare Law.

Maintained active liaison with Pennsylvania Blue Cross Plans which serve as the primary fiscal intermediaries for Part A, Title XVIII of the Medicare Law.

Provided professional guidance and administrative assistance to Councilor District Review Committees; those concerned with disputed claims involving physicians' fees and those that evaluate hospital utilization problems submitted by Pennsylvania Blue Cross Plans.

Initiated a new inquiry into the possibility of establishing a statewide Society-endorsed malpractice insurance program and continued to assist members in securing coverage, upon request.

Urged the Department of Public Welfare to contract with Pennsylvania Blue Shield in implementing the Pennsycare program and was instrumental in bringing about the execution of an agreement under which, effective June 1, 1968, Pennsylvania Blue Shield began serving as the fiscal intermediary for this program as it pertains to processing claims for in-patient services provided by physicians.

Continued to meet regularly with representatives of the Department of Public Welfare in an effort to obtain needed improvements in the Pennsycare program, Title XIX of the Medicare Law, in accordance with the Society's recommendations of May, 1967.

Assisted in the preparation of Medical Society testimony presented jointly on behalf of the Pennsylvania Medical Society and County Medical Societies at five public hearings called by the State Insurance Department relative to rate increase requests by the five Pennsylvania Blue Cross Plans.

Continued close surveillance over Society-endorsed insurance programs. Recommended that the Society withdraw its endorsement of insurance programs offered by the Insurance Company of North America; such endorsements to be transferred to comparable programs of insurance offered by the Commercial Insurance Company of Newark, New Jersey no later than October 15, 1968.

Maintained active liaison with the Social Security Disability Determination Division, Bureau of Vocational Rehabilitation, and Pennsylvania Department of Labor and Industry regarding professional matters of mutual interest.

Expanded the membership and increased the scope of activities of the Commission on Health Facility Planning (renamed the "Commission on Comprehensive Health Planning" on May 15, 1968) in an effort to assist the Pennsylvania Department of Health as they undertake to implement P. L. 89-749, "Partnerships for Health Legislation."

COUNCIL ON PUBLIC SERVICE

The Council on Public Service has expanded its radio activities and the State Speakers' Bureau, has changed emphasis in its TV involvement and in press activities, has seen its Commission on Disaster Medical Care become a national leader and has, at a minimum, held the line in other areas despite limited funds and rising costs.

In radio, the weekly five-minute program produced by the State Society for eighty stations continues its high level of acceptance and the "Instant News" special service for radio stations has been expanded to include local recordings by county medical societies that have chosen to participate. The major expansion has occurred in the special programs—"Mini-Documentaries"—being offered to all radio stations on such subjects as the Medical Examiner System, Venereal Disease, Drug Abuse, Traffic Safety and Air Pollution.

Lack of funds has forced the Council to postpone any production of television documentaries and the Council instead has begun producing its own TV public service spot announcements with color slides and scripts and sound-on-color-film.

Changes in newspaper activities have involved improved liaison efforts and a pending request to abandon the annual Harrisburg area Press Party in favor of increased liaison efforts at the Annual meeting of the Pennsylvania Newspaper Publishers' Association and the Penn-

sylvania Society of Newspaper Editors. News release and health column activity has remained at a high level.

The Commission on Disaster Medical Care has involved representatives of various levels of municipal officials in a state Council on Community Disaster Planning which now appears to have pending a vital role in the implementation of the Highway Safety Act in Pennsylvania. The Commission's emphasis on community planning has been a model for the AMA and other states.

In response to an ever-growing number of requests, the Council expanded the membership of the state Speakers' Bureau to almost fifty and is planning a workshop for the members.

A proposed expansion of the Donaldson Award program for outstanding medical reporting to include big and small groups within each of the three categories is pending at the writing of this report. The Benjamin Rush, Fifty-Year and Centenarian Awards continue their high level of activity.

Additional Future Physicians Clubs were formed as part of the Medical Student Recruitment program and upon recommendation of the Council, the State Society endorsed the Medical Explorer Posts program of the Boy Scouts of America.

Pennsylvania SAMA Chapter representatives have been invited to meetings of the Council. The Council is in

the final stages of preparations for presenting a socio-economic course to interns and residents at two hospitals on a trial basis.

The Council has assisted the Pennsylvania Association of Medical Assistants in its worthy program to gain new members . . . Pamphlet distribution has decreased because of increased costs . . . The county society secretary orientation visits to the State Society are continuing . . . Primary responsibility for anti-quackery activities was transferred to the Council on Governmental Relations

COUNCIL ON SCIENTIFIC ADVANCEMENT

The following is a summarization of Council activities:

The Council recommended to the Board of Trustees that the Committee on Convention Program and the Commission on Medical Education be combined into a single group to be a Commission on Education.

The Council informed county medical societies that they should conduct mass immunization programs at their discretion.

During the past year, the Pennsylvania Committee on Smoking and Health of Youth, of which the Society is a member, has taken a stronger position and made recommendations to its various component groups regarding cigarette smoking.

Seven Emergency Techniques Training Programs were presented across the Commonwealth. Attendance averaged 125 persons per program. One fourth were physicians, the remainder were nurses with special interest in the emergency department.

Two programs of the Pennsylvania Heart Coordinating Committee have been taken over by other agencies. The first, a four-point program on cardiovascular diseases, is being studied by the regional medical programs, the second, the development of cardiopulmonary teams, has been assumed by the Pennsylvania Heart Association.

The Pennsylvania Cancer Coordinating Committee is particularly interested in promoting proctosigmoidoscopy. Cancer of the lower bowel, including the rectum, is the leading cause of cancer deaths. To reduce these deaths, early detection and early treatment is necessary. Proctosigmoidoscopy is an effective means for early detection.

The recent worldwide publicity regarding transplant operations has aroused the interest of certain citizens of Pennsylvania in the procedures necessary to become a donor.

Many inquiries were being received by the State Society office; and in an effort to satisfy these referrals, the Council compiled data and now provides a body parts and organ transplant information service for inquiring persons.

A special committee of Council members met with Pennsylvania Blue Shield to discuss manpower requirements and to initiate a long-term study to delineate roles of paramedical personnel in rendering of medical service.

CHRONIC ILLNESS AND GERIATRICS—The Commission had been concerned over the fact that drivers over sixty-five years of age are sometimes denied licenses because auto insurance is not available. On June 5, 1968, Governor Shafer signed a compromised version of a bill to halt the arbitrary cancellation of automobile insurance because of age, residence, race, color, creed, national origin,

. . . Upon the recommendation of the Council, the Commission on Rural Health will be abolished upon termination of this year's House session and the Commission's responsibilities will be assumed directly by the Council.

The Council hopes that this summary will lead you to a reading of its full annual report where the items mentioned above, along with an accounting of many other activities, are completely explained. The full report will appear in the Official Reports Booklet and copies are available to any PMS member upon request.

and ancestry or lawful occupation, including the military service.

Under study is a new table of organization titled "Continuity of Health Care Under a Comprehensive Health Planning Program." The Commission's concern has been the definition and delineation of the levels of health care available outside the hospitals, which would be of some significance to the physician.

DRUG ADDICTION AND ALCOHOLISM—Contact was made with all Pennsylvania hospitals encouraging them to provide inpatient and outpatient facilities for alcoholics.

The Commission reviewed House Bill No. 1420 on the control and use of LSD and found no objection to the legislation.

Until there is greater understanding about marijuana and its dangerous attributes, the Commission adopted the position of the American Medical Association on the use of marijuana.

ENVIRONMENTAL HEALTH—Housing codes for third-class townships and rural areas were reviewed by the Commission.

The Commission recommended that in the interest of quality control, efficiency, and economy, the concept of one central reference laboratory for analyzing environmental pollutants for the State Department of Health is the best approach to this problem instead of a series of small satellite laboratories.

Governor Shafer was commended for his program to provide optimal environmental conditions for the health of the citizens in the Commonwealth and the Legislature was urged to take the necessary action to implement the Governor's plan.

MATERNAL AND CHILD HEALTH—The Ninth Annual Institute on Maternal and Child Health was held April 11, 1968.

Recent papers strongly suggest that phenylketonuria in an expectant mother, who actually herself may not be mentally retarded, is frequently associated with foetal damage in utero, resulting in the birth of a mentally retarded infant. As a step in the direction of preventing further retardation in the next generation, the Commission is recommending that all G.P.s, obstetricians and pediatricians be notified of the problem of identification of PKU mothers and suggest Phenistex testing of routine urine analysis be done and positive findings sent to the Pennsylvania Department of Health.

MEDICAL EDUCATION—The licensing of paramedical personnel by the State Board of Medical Education

and Licensure was given continued support by the Commission.

Announcements listing continuing medical education courses were published in *PENNSYLVANIA MEDICINE*.

Still under study is the concept of "medical assistant."

The preceptorship program is at a standstill because the logistics in financing seem to be the biggest implementation stumbling block in the medical schools.

The coordination of continuing medical education programs in the Susquehanna Valley area has been temporarily suspended pending the outcome of an organizational structure within the Society regarding medical education.

MENTAL HEALTH—A Commission member appeared before a joint Senate-House Committee to testify on Senate Bills No. 1274, which would adopt minimum standards for treatment in mental hospitals, and No. 1275, which would provide for the remuneration of services rendered by mental hospital patients.

A statement was submitted at a hearing to review the regulations for the county mental health and mental retardation program. The Commission expressed its concern for appropriate medical surveillance and confidentiality of records.

The Commission also went on record as favoring the extension of prepaid insurance coverage for psychiatric illnesses, both for inpatient and outpatient care.

Continuing education courses in psychiatry will be included in the continuing education listings appearing in *PENNSYLVANIA MEDICINE* as the result of cooperation with the Pennsylvania Steering Committee for Continuing Education in Psychiatry.

OCCUPATIONAL HEALTH—1967 Occupational Health Awards were presented to Merck, Sharp & Dohme, Division of Merck & Co., Inc., nominated by Montgomery County Medical Society; Equitable Gas Company, nominated by Greene County Medical Society; Westinghouse Electric Corporation, nominated by Delaware and Mercer County Medical Societies.

As a further means of stimulating interest among management personnel in occupational health, the Commission

is considering approaching leading business schools to institute occupational health education in their curriculum.

The Commission is exploring the formation of a committee to review existing Workmen's Compensation problems in Pennsylvania and arrive at specific recommendations.

SCHOOL HEALTH AND SPORTS INJURIES—The Commission assisted in the preparation of *Guidelines for Curriculum Development in Health Education* through the Department of Public Instruction's State Health Education Advisory Committee.

Under consideration is a 1969 conference that would concern itself with the practical application of physiology to athletics. This new approach to sports injuries would include such topics as heat stress, nutrition, drugs, the physiology of exercise, maximal work capacity, cardiopulmonary response to exercise, physical conditioning, sustained work loads during athletics, environmental considerations in relation to athletics, and nutrition of the athlete.

TRAFFIC SAFETY—A special licensing procedure for epileptics, meeting the requirements of the Pennsylvania Automobile Assigned Risk Plan, has been achieved by the Commission. Effective February 1, 1968, the Pennsylvania Automobile Assigned Risk Plan was amended to provide coverage to any individual suffering from epilepsy or any other convulsive disorder, providing such individual has, after making such physical condition known to the Commonwealth's Bureau of Traffic Safety, met the Bureau's requirements with respect to motor vehicle operator physical impairments, and has been given a valid license to drive.

Commission members met with representatives of the State Police and the Secretary of Highways to plan for the handling of emergency cases during severe snowstorms.

The Bureau of Environmental Health, Pennsylvania Department of Health, was asked to incorporate guidelines on priorities for evacuation of patients in accidents involving more than one person in the Ambulance Attendant Training Manual now being revised. Seven hundred fifty hours of physician time was given voluntarily to these training programs.

PENNSYLVANIA DELEGATION TO AMERICAN MEDICAL ASSOCIATION

A full complement of delegates from Pennsylvania attended the Sessions of the House of the American Medical Association House of Delegates in Houston, Texas November 26-29, 1967 and in San Francisco, California June 18-22, 1968.

As mandated by the 1967 House of Delegates of the Pennsylvania Medical Society, the Pennsylvania Delegation introduced eight resolutions at the November meeting titled as follows:

1. Hospital Attendance Regulations;
2. Communications with Boards of Trustees in Hospitals;
3. Malpractice Insurance;
4. American Medical Association Membership;
5. Bicentennial Celebration of the Declaration of Independence;
6. Establishment of Utilization Committees in Veterans Administration and Public Health Service Hospitals;

7. Administrative Costs of Medicare;

8. Study of Methods of Delivery of Health Services.

At the June 1968 meeting of the AMA House of Delegates the Pennsylvania Medical Society presented a resolution which requested the American Medical Association to seek to establish a standard wearing place for the Emergency Medical Identification Symbol and, if successful, promote through existing mechanisms public awareness of the establishment of the standard wearing place and that consideration for the standard place be given to the wearing of this device on a neck chain. This resolution was not approved.

Russell B. Roth, M.D., of Erie, was unanimously elected as Vice Speaker of the AMA House of Delegates for the coming year and Elmer G. Shelley, M.D., of North East, was elected Chairman of the Judicial Council.

The Delegation noted with regret the resignation of John S. Donaldson, Jr., M.D., of Pittsburgh, as a Delegate to the American Medical Association.



**HILTON HOTEL
PITTSBURGH**

**44th ANNUAL AUXILIARY
CONVENTION**

SEPTEMBER 26-27-28-29, 1968

**SPECIAL HIGHLIGHT
10TH ANNUAL PENNSYLVANIA
PHYSICIANS ART EXHIBIT**

*Is
Medicine
in his
Future?*

IT COULD BE WITH YOUR HELP!

FILL THE DEMAND FOR MORE PHYSICIANS WITH YOUR SUPPORT OF

MEDICAL STUDENT RECRUITMENT PROGRAM OF THE PENNSYLVANIA MEDICAL SOCIETY
MEDICAL EXPLORER PROGRAMS OF THE BOY SCOUTS OF AMERICA
WRITE TO THE P.M.S. COUNCIL ON PUBLIC SERVICE FOR DETAILS.





Why Continuing Education?

(Editor's Note: The following abstract was prepared from a transcript of a panel discussion of the Task Force on Continuing Medical Education appointed by the Board of Trustees and Councilors of the Pennsylvania Medical Society which took place March 7, 1968. The participants are: David S. Masland, M.D., task force director; Robert L. Evans, M.D., York; George T. Harrell, M.D., Hershey; John H. Moyer, M.D., Philadelphia; William A. Limberger, M.D., West Chester, and Arthur D. Nelson, M.D., Philadelphia.)

DR. MASLAND: The need for a change and for immediate action is clear; the PMS should move in or get out of continuing medical education. The Convention Program Committee has shown that participation has decreased while improvement of the program has taken place. Financial support by outside sources is decreasing and may terminate. We must change or drop the program. If a new program is to be instituted who will implement it?

DR. NELSON: First we must understand the nature and extent of our problem. The philosophy and objectives of the PMS in the field of continuing education must be identified. The relationship of the Society to the individual member needs definition. This is a professional society and must maintain standards, principally standards of high quality care. We must decide who has the problem—is this a problem of the isolated practitioner, the medical school faculty, or the group practice segment of the society? Goals of maintaining quality of patient care are paramount but there are also considerations such as cost, organization, and distribution of medical care and application of medical care resources and of medical knowledge, which must concern the PMS. Our solutions must be worked out in relation to regional medical programs (P.L. 89-239), and the Partnership for Health (P.L. 89-749).

Methods of getting continuing education to all of our members, and techniques for improving such education must be studied. We need information as to whether or not continuing education improves patient care. We must find out what doctors see as their need; we must try to achieve more involvement and more motivation on the part of practitioners. We need alternatives to present methods of education. Perhaps instant consultation and instant problem-solving for the physician should be studied. We must also consider alternative mechanisms for requiring continuing education, such as licensure, certification, and medical audit and review in and outside the hospital. The accountability of the practitioner to society is receiving more and more public attention.

DR. MOYER: Fragmentation of continuing education is a major defect in getting an overall program developed. It is a question of whether or not the PMS should be involved in continuing education unless we can get an outstanding program developed. The PMS might coordinate local, state, and national efforts of all agencies. It is in the best position to be an umbrella agency, but this requires internal coordination in the society before coordination of satellite groups can be undertaken.

DR. HARRELL: The question of whether we should provide or simply correlate educational efforts needs to be studied. We must stimulate and motivate the M.D. but his work makes it difficult for him to undertake continuing education. Self education techniques at the time and place of the doctor's choosing are essential, e.g., radio and television programs. Telephone programs can do this although they do not have enough flexibility or feedback to be ideal. One day teaching institutes may have more impact on what the hospital does. A longer span of education, however, shows evidence of increased retention of learning. Compulsion is of doubtful value though the PMS's responsibility for standards is clear. Papers delivered to an audience have a little less value than published papers. Better yet is the scientific exhibit. It is worthy of comparison with the efforts of the "detail man." We cannot, however, achieve a team to visit every state physician every three months; but we can do things like present patients in whom the doctor is personally involved. We might undertake a "retread" residency type of experience for three months, every five to seven years. An experiment of this type has proved to be very effective. Recruiting and financing of such studies however, is very difficult because of the problem of coverage of the physician's practice. Actually, he needs something which can be done in *hours*. In the case of group practice, coverage is simpler. In summary, we need two techniques, 1) a residency type with individual instruction, and 2) teaching machines. The PMS can perform the latter and encourage the former. Scientific meetings and short courses are probably not very effective.

DR. EVANS: The PMS should be a learned society and responsible for stimulating continuing education if not certification. If not, it is a trade association. The content of the program should be reparative education. The goal is to have the M.D. achieve 70 percent of the knowledge

in his field. Active education (involving the physician in his own education) is preferred to passive, although passive (principally lectures) is not all bad. Research is the one extreme of active education and the lecture the other extreme. Validation of educational experience where the doctor works—to see the subject or technique work in his setting—is important. Goals and objectives must be set. We need information on the problem; we need information as to content which is needed to improve patient care. At York, success has been measured by good attendance and by measured change in practice pattern. The method at York has been to find out the students' wants and use judgment in supplying them. An attempt is made to cover an entire field over a period of four or five years, to use passive as well as active methods and to employ the

problem and continuing education must be left to their own specialty societies. Too few individuals in one area make continuing education an inefficient affair. A five day course at a medical college can give appreciable coverage to a narrow specialist's particular field.

DR. HARRELL: The lecture is still the only effective method to teach a group and is particularly effective with certain people. It puts things in perspective, summarizes and interprets.

DR. MOYER: The value of a good lecture depends upon the proficiency of the listener. Assimilation of information in this form is good by one well-acquainted with the field. (To Dr. Nelson's objection that this may miss the man that needs it most, Dr. Moyer agreed, but all physi-



DR. EVANS



DR. NELSON



DR. MOYER

principle of reparative education, with review, and attempts to apply the same stimulators for retention as are used in the education of youths. Repetition is necessary. Attempts to motivate consist mainly in making the material pertinent, local, and personal.

Gimmicks may also be used, such as the teaching machine, TV, etc. The hospital or county medical society could do the latter. The physician on the hospital board can help with continuing education. Cooperation between the county society and the hospital is increasing and may help with continuing education. The regional medical programs may coordinate it. Medical colleges are sources of talent but cannot be responsible for running continuing education since they are already strained by their teaching and research function. They are, however, a reservoir of skilled teachers.

Motivation comes from a good program with able teachers rather than famous ones. This has given better attendance, it has established habits of attendance. Stimulation and motivation of individuals and groups—word of mouth advertising—is notable. Varied specialties with different needs exist, but the family doctor, the internist and the surgeons and pediatricians have a common need of a broad base of fundamental knowledge and can be treated somewhat as a group. Narrow specialties create a

cians need a regular audit of new developments, which can be accomplished quite adequately with a good lecture making use of readily available teaching aids.)

DR. MASLAND: Though some do not retain all, physicians are still well enough acquainted with basic material (for example, treatment of diabetes) that the general lecturer can bring them up to date in a reasonable fashion and it is enhanced in value if repeated in six to twelve months.

DR. EVANS: The evaluation of results has shown that expert speakers received approval of listeners, but they do not change their own methods in practice. A gifted teacher, working in a grand rounds session can and does influence the way people handle patients, i.e., the patients whose conditions have been studied.

DR. NELSON: But many doctors have not had access to programs like those of Dr. Evans. Surveys of patient care reveal instances of inadequate investigation and inadequate therapy. The Society should, therefore, be active in developing educational programs. But, how? At what level?

DR. MOYER: It was concluded at the 1964 Pa. Conference on Medical Education that continuing education

is a day-to-day event and ought to take place where the doctor works, and that the State Society should stimulate, motivate and evaluate; the local society should administrate and coordinate and the local hospital might provide facilities. The long-range planning committee of the state society Committee on Convention Program felt that one of the major problems is coordination of the various efforts and that regional medical programs could be incorporated in the overall approach as could the medical schools. Multiple techniques are the essence of an educational program. It is agreed that direct supervision at the bedside is the bread and butter of the whole business—i.e., direct application, but we could use conferences or seminars for the regional type program which would emphasize basic sciences application and recent developments. And there still may be

DR. MOYER: Let me outline what we emphasized at previous meetings of the Convention Program Committee. For example, we thought that we might have a cardiologist from each of our seven medical schools talk about pathophysiology of heart failure at the annual State medical meeting. This would be carried further in regional meetings which could be highly specialized, but more directly related to patient care. Then the program could be further decentralized subsequently to the hospital level and could get into the clinical manifestations of disease, diagnosis, and therapy. Local people could be involved easier. Even at the regional meetings (western, central and eastern programs) people could attend without too much difficulty. The same instructors might subsequently participate in the area hospital programs and thus develop a direct aggres-



DR. MASLAND



DR. LIMBERGER



DR. HARRELL

larger groups meeting to attend symposia and the like. It should be noted that some types of information can be given in this manner of presentation just as well as at the bedside. For example, the pathophysiology of heart failure can be taught better with blackboard and demonstrative material than by wheeling the patient into the lecture hall since the essence lies in biochemistry, not in the patient's face. Multiple techniques should be the order of the day for a total educational program and we should develop a totally coordinated, long-range program which extends over years and not a last-minute operation planned only a few months in advance.

DR. EVANS: Leadership as a learned society is passing from medical society to hospital staffs because medical societies are preoccupied with non-scientific problems and the hospital staff is better organized, better operated and more efficient. I do not hold that this is good or bad—simply that it is happening. Local groups that are highly organized are perhaps better able to carry out programs of continuing education than medical societies which may have many component bodies concerning themselves with education, thus having confusing reduplication. The role of the medical society is really the coordination of this kind of activity, the development of a multi-phase approach, including medical colleges.

sive approach. The same clinicians might well go into these same hospitals twice a year to review the management of current patients with staff. Analysis and critical review of the way these patients were handled is a desirable method of evaluation and differs from the distant, academic approach. Only an umbrella type organization like the state society or the federal government could do this.

Dr. Harrell pointed out that this was one of the objectives of the regional medical program and Dr. Masland, that this was one of the goals of our federal government.

DR. LIMBERGER: A method to demonstrate to the primary physician his defects and knowledge of modern methods of treatment and diagnosis is needed. An exam similar to that given by the American College of Physicians might be useful. A sample of a thousand such exams taken by primary physicians might produce the valuable information we need for the development of a continuing education program.

Further study by the Committee consisted of a discussion of the program of the American Academy of General Practice and the value in continuing medical education of their program for certification.



Adrenergic Blocking Agents in Cardiovascular Disease

Part II

Can propranolol be used in the differential diagnosis of cardiac arrhythmias?

In the tachycardias a more definitive electrocardiographic diagnosis can be made by the slowing of the heart rate with propranolol, either by decreasing the rate of the pacemaker or by decreasing A-V nodal conduction. One mg. (1 cc.) should be administered intravenously in approximately one minute. A second dose may be given after two minutes.

How may propranolol be used in converting atrial arrhythmias to normal sinus rhythm?

It is seldom an effective drug when used alone in converting atrial fibrillation or atrial flutter to a normal sinus rhythm. However, some physicians have had success in converting atrial flutter and atrial fibrillation with a combination of digitalis, quinidine and propranolol. The recommended dosage is: *First day*: digitoxin, 0.6 mg. twice daily, quinidine, 0.2 gm. every two hours for five doses; *second day*, digitoxin, 0.15 mg., quinidine 0.3 gm. every two hours for five doses; *third day*, digitoxin, 0.15 mg., quinidine, 0.4 gm. every two hours for five doses and propranolol, 20 mg. every six hours; *fourth day*, digitoxin 0.15 mg., quinidine 0.4 gm. every two hours for five doses and propranolol 30 mg. every six hours; *fifth day*, digitoxin 0.15 mg., quinidine 0.4 gm. every two hours for five doses and propranolol 40 mg. every six hours. If this is not effective, other measures can then be used. The combination of digitalis and propranolol is effective in most cases of paroxysmal atrial tachycardia.

How can propranolol be used in the prevention of arrhythmias?

Arrhythmias can be prevented by propranolol in the Wolfe-Parkinson-White syndrome as retrograde A-V conduction is blocked. Exercise-induced arrhythmias can also be prevented. Propranolol is rarely good alone in the prevention of paroxysmal

atrial fibrillation or atrial flutter. However, the combination with digitalis glycosides or quinidine may increase the effectiveness. One of its most effective uses has been to treat the digitalis-induced cardiac arrhythmias and to treat arrhythmias precipitated by anesthesia.

In what other way may propranolol be used in the management of arrhythmias?

It can be used to slow ventricular rate and eliminate ectopic beats. In these cases the oral route of administration is preferred, the usual dose being 10 to 30 mg. every six to eight hours. In supraventricular tachycardias with rapid ventricular rates and in the emergency treatment of ventricular tachycardia (prior to xylocaine or electrocardioversion) the drug should be given intravenously, 1-3 mg., under ECG monitoring. However, the rate of administration should not exceed 1 mg. (1 cc.) per minute.

Is propranolol of value in the treatment of angina pectoris?

Propranolol decreases the myocardial oxygen requirement by slowing the heart rate, decreasing the rapidity and strength of myocardial contraction, decreasing the cardiac output and decreasing the systolic blood pressure. Propranolol does not increase the coronary blood flow. Some physicians have found it effective in angina pectoris, but it is most effective when combined with the sublingual use of the long-acting nitrates, such as isorbide dinitrate or erythrol tetranitrate. Propranolol should be given in doses of 10 mg. every six hours and increased gradually at three to five-day intervals to a maximum of 80 mg. every six hours combined with 5 to 10 mg. of erythrol tetranitrate or 5 mg. of isorbide dinitrate sublingually every six hours. The propranolol should be maintained at the level at which symptomatic improvement occurs. I have found it to be effective in reducing recurrent or persistent pain

in patients with myocardial infarction who have no signs of myocardial failure.

What are the contraindications to the use of propranolol?

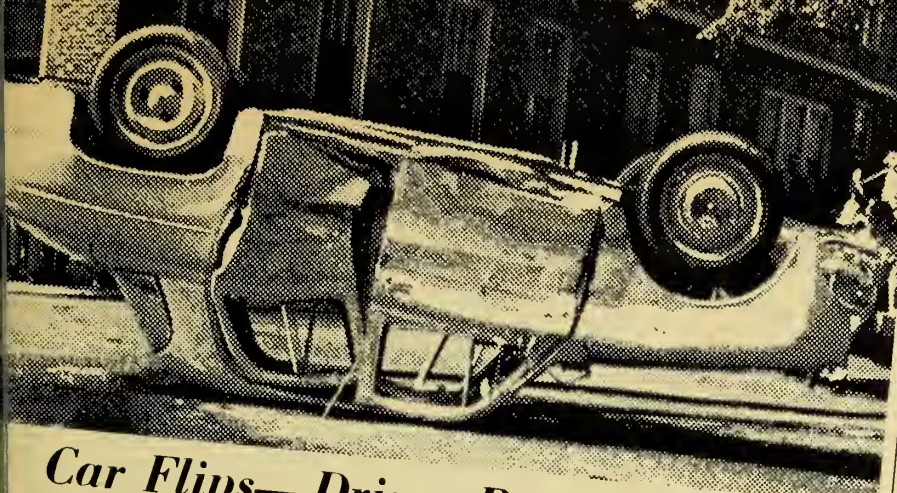
This drug has inherent dangers because of its beta blocking action. It is contraindicated in patients with myocardial failure or a history of dyspnea, as it decreases the contractile force of the myocardium. It is also contraindicated in bronchial asthma, chronic pulmonary disease, allergic rhinitis, sinus bradycardia, A-V heart block, cardiogenic shock, a systolic blood pressure below 90, episodes of spontaneous hyperglycemia or emotional depression. Extreme caution should be used in giving propranolol to patients on insulin or oral hypoglycemic drugs.

What are the antidotes for the toxic effects of propranolol?

A slow pulse or A-V heart block should be treated with atropine sulphate, 0.5 to 1.0 mg. intravenously. Isoproterenol can also be used in a dosage of 1 to 2 mg. in 500 cc. of five percent glucose and water. Glucagon, 1 mg., either intravenously or intramuscularly, is excellent since it acts like a catecholamine and increases the contractile force of the heart, the heart rate and A-V conduction time. It will also increase the blood sugar and, therefore, is the most useful drug in the treatment of hypoglycemia precipitated by the beta-blocking agent.

■ William G. Leaman, Jr., M.D. questions M. Price Margolies, M.D., Chief of the Department of Medicine and Director of the Heart Station, Coatesville Hospital, Coatesville, Pennsylvania.

■ William G. Leaman, Jr., M.D. Fellow, Council on Clinical Cardiology of the American Heart Association, edited this Brief for the Council on Scientific Advancement, in cooperation with the Pennsylvania Heart Association.



Board n
stater
issue, a
tember t
fications
ton dicta
Althoug
made Mo
down by a
ter shar
flat obje
was pass
Board
McCredi
tion" s
elimir
the st.
The c
ment ca
limit re
mile li
"cut-of
public
dren
priv
be b
or th
schoo
The
so so
rather
hurs

Car Flips—Driver Breaks Leg

is, Sept. 7. John P. Jones of
no incurred a broken leg today
driving failed

Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its top
Hasn't he been driving it for

STAFF PHOTO

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic $\frac{1}{4}$ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* ($\frac{1}{4}$ gr.), 16.2 mg. (Warning: may be habit forming); *Aspirin* ($2\frac{1}{2}$ gr.), 162.0 mg.; *Phenacetin* (3 gr.), 194.0 mg.; *Hyoscyamine sulfate*, 0.031 mg.; *Codeine Phosphate*, $\frac{1}{4}$ gr. (No. 2), $\frac{1}{2}$ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 **A-H-ROBINS**



a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor).....	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B ₁₂ activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.).....	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate).....	110	mg.
Ascorbic Acid (Vitamin C).....	75	mg.
Folic Acid.....	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B₁₂ therapy may result in hematologic remission but no neurological progression. Adequate doses of vitamin B₁₂ (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B₁₂. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B₁₂, may be necessary. No single regimen fits all cases, and the status of the patient observed over follow-up is the final criterion for adequacy of therapy. Periodic

You can treat combined
deficiencies with

Trinsicon®

—the multifactor hematinic



Vitamin B₁₂ plus intrinsic factor (15 mcg. B₁₂ activity)—helps provide adequate levels of this important vitamin.



Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.



Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.



Iron (110 mg.)—treats hypochromic anemia.

Clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500.

[032560]

Additional information
available to physicians
upon request.

Eli Lilly and Company,
Indianapolis, Indiana 46206.

801668



the ^{In peptic ulcer:} antacid puzzle



solved by
Mylanta[®]
aluminum and magnesium hydroxides plus simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients — after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.



Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.



(New TUBEX[®] are constantly being added)



Only
TUBEX[®]
offers
so complete
a line of
closed
system
injectables

and
it's still
growing.

To meet your present needs more precisely, the Tubex line comprises 37 different products in 69 dosage variations. And more are on the way.

Tubex offers these unit dose advantages:

- **accuracy**—premeasured, clearly labeled to help ensure correct medication
- **convenience**—no filling, no needle-sharpening, no sterilization, no cleanup
- **simplicity**—precision-made, well balanced syringe breech loads in seconds, permits easy aspiration
- **reduces risk**—single-use cartridge-needle units reduce risk of cross contamination; less chance of spillage reduces risk of contact sensitization for doctor or nurse
- **stability**—glass cartridges can't deteriorate or react with medication
- **acceptability**—presharpened, siliconized needles lessen pain of injection; patients appreciate single-use equipment

Just select, inject, throw away

TUBEX[®]



sterile cartridge-needle unit

Wyeth Laboratories Philadelphia, Pa.

When it's time for Thorazine® brand of chlorpromazine



...can you depend on less?

For profound calming effect in moderate to severe mental and emotional disturbances of everyday practice.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion;

constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

©1967, 1968 Smith Kline & French Laboratories

Smith Kline & French Laboratories, Philadelphia





⊙ Indicates courses being conducted in Pennsylvania.

ALLERGY

⊙ **Allergic Practice;** by Albert Einstein Medical Center; at *Philadelphia, Thursday, September 19-November 21, 1968*; AAGP 3 hours; minimum required 15, maximum permitted 25; fee \$75. Contact Solomon Mintz, M.D., Albert Einstein Medical Center, York and Tabor Roads, Philadelphia 19141.

CARDIOVASCULAR DISEASE

⊙ **Cardiology;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Thursday, September 5, 1968*; fee \$2150. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

⊙ **Short Course on Cardiac Arrhythmias;** by Jefferson Medical College and Penn State University; at *St. Luke's Hospital, Bethlehem, Thursday, September 19, October 17, November 21 and December 19, 1968*; 9:30 a.m. to 12 noon; fees: \$16 for four sessions; \$7 per single seminar; AAGP 3 hours per session. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

⊙ **Heart Block;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at *Wyoming Valley Hospital, Wilkes-Barre, Wednesday, September 25, 1968*. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

⊙ **Heart Failure;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at *Wyoming Valley Hospital, Wilkes-Barre, Wednesday, September 25, 1968*. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

⊙ **Cardiac Resuscitation;** by Hahnemann Medical College and Grand View Hospital, Sellersville; at *Grand View Hospital Nurse Home, Sellersville, Wednesday, September 25, 1968*. Contact D. Henry Ruth, M.D., Grand View Hospital, Sellersville, Pa. 18960.

CHEST DISEASES

⊙ **Broncho-Esophagology;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Monday, September 9-21, 1968*; fee \$250. Minimum required 10, maximum permitted 25. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

DERMATOLOGY

⊙ **Dermatology;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Thursday, September 5, 1968-May 15, 1969*; fee \$2150. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

ELECTROCARDIOGRAPHY

⊙ **Basic Electrocardiography;** by Albert Einstein Medical Center; at *Samuel H. Daroff Division, Philadelphia, Wednesday, September 25, 1968-January 8, 1969*; AAGP 42 hours; maximum number permitted 30; fee \$75. Contact Solomon Mintz, M.D., Albert Einstein Medical Center, York and Tabor Roads, Philadelphia 19141.

ENDOCRINOLOGY

⊙ **Hypothyroidism and Hyperthyroidism;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at *Wyoming Valley Hospital, Wilkes-Barre, Wednesday, September 11, 1968*. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

GASTROENTEROLOGY

⊙ **Gastroenterology;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Thursday, September 5, 1968-May 15, 1969*; fee \$2150. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

GENERAL

⊙ **The Physiologic Control of Hospital Emergencies;** by Pennsylvania Medical Society, Hospital Association of Pennsylvania, Pennsylvania Departments of Health and Welfare; at locations listed below; commencing 1:30 p.m.; fee \$5. Contact Richard B. Magee, M.D., Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043. *Thursday, September 19, 1968, Westmoreland Hospital, Greensburg; Thursday, October 17, 1968, Lancaster General Hospital, Lancaster; Thursday, November 14, 1968, Sharon General Hospital, Sharon.*

⊙ **Electrophoresis;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at *Wyoming Valley Hospital, Wilkes-Barre, Wed-*

nesday, September 18, 1968. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

⊙ **Treatment of Emergencies;** by Episcopal Hospital; at *Philadelphia, Wednesday, October 23-November 13, 1968*; AAGP 8 hours; no fee; minimum number required 50, maximum permitted 100. Contact L. H. Stahlgren, M.D., Episcopal Hospital, Front St. & Lehigh Ave., Philadelphia 19125.

⊙ **Group Practice;** by Pennsylvania Medical Society; at *Chatham Center, Pittsburgh, Sunday, October 27, 1968*. No fee. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

GENERAL MEDICINE

⊙ **Medicine;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Thursday, September 5, 1968-May 15, 1969*; fee \$2150. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

⊙ **Postgraduate General Medicine Education;** by Harrisburg Hospital; at *Harrisburg, Tuesday, September 10, 1968-June 10, 1969*; no fee; one hour per day, 23 days. Contact C. W. Smith, M.D., Harrisburg Hospital, South Front St., Harrisburg 17101.

⊙ **Continuing Education;** at *Pottsville Hospital; Thursday, September 12, 1968 to June 1969*; one day per month, 10 months; no fee; AAGP credit 20 hours. Contact E. W. Cubler, M.D., Pottsville Hospital, Pottsville 17901.

⊙ **Current Concepts of Thyroid Disease;** by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, September 12, 1968*; 11:30 a.m. to 2 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

⊙ **Retraining Program for Women Physicians;** by Women's Medical College of Pennsylvania; at *Philadelphia, Monday, September 23, 1968-May 28, 1969*; 672 course hours; no fee (stipend offered); minimum required 5, maximum 10. Contact Ethel Weinberg, M.D., Assistant to the Dean, Women's Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia 19129.

INTERNAL MEDICINE

○ **Current Status of Antibiotics;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, *Wilkes-Barre, Wednesday, September 18, 1968.* Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

MISCELLANEOUS BASIC SCIENCES

○ **Correlated Basic Sciences Lectures;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Monday, September 9, 1968-January 20, 1969;* fee \$500. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

NEUROLOGY

○ **The Neurologist Looks at Stroke;** (Modern approaches to diagnosis and care); by Jefferson Medical College and York Hospital; at *York, Thursday, September 26, 1968;* fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Face Pain—Clinical Evaluation and Treatment;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, *Wilkes-Barre, Wednesday, October 23, 1968.* Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

NEUROSURGERY

○ **The Neurosurgeon Looks at Stroke;** (The acute approach to repair and prevention of spread); by Jefferson Medical College and York Hospital; at *York, Thursday, October 3, 1968;* fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Two day visit, October 3 and 4. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Panel: Interesting Neurosurgical Cases;** by Pennsylvania Medical Society and Mid-Atlantic Neurosurgical Society; at Chatham Center, *Pittsburgh; Tuesday, October 29, 1968.* No fee. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

ORTHOPEDICS

○ **Orthopedic Surgery;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Thursday, September 5-December 21, 1968;* maximum number 25; fee \$1075. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs.,

36th & Hamilton Walk, Philadelphia 19104.

OTOLARYNGOLOGY

○ **Otolaryngology;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Saturday, September 21-December 21, 1968;* fee \$925. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

PEDIATRICS

○ **Pediatrics;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Thursday, September 5, 1968-May 15, 1969;* fee \$2150. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Medical Labs., 36th & Hamilton Walk, Philadelphia 19104.

○ **Up to the Minute Pediatrics;** by Woman's Medical College of Pennsylvania at *Philadelphia, September 1968-May 1969;* 4 to 5 hours monthly for seven months; fee \$5 per session (lunch included). Contact Ethel Weinberg, M.D., Assistant to the Dean, Woman's Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129.

PHYSICAL MEDICINE AND REHABILITATION

○ **The Psychiatrist Looks at Stroke;** by Jefferson Medical College and York Hospital; at *York, Thursday, October 10, 1968;* fee \$50 for 112 hour, 28 day Continuing Seminar in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

PSYCHIATRY

○ **Physician—Community Psychiatrist Seminar;** by Mental Health Guidance Clinic of Butler County, at Y.W.C.A., 120 West Cunningham St., *Butler, 4th Friday of each month, September through June;* AAGP credit, hour for hour; maximum number permitted 20. Contact Robert L. Eisler, M.D., Mental Health Guidance Clinic of Butler County, 128 South Main St., Butler 16001.

○ **Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *Reading Hospital, Wednesday, September 11-December 11, 1968;* fee \$15; minimum number required 15, maximum permitted 25. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Sexual Problems in Medical Practice;** by Hahnemann Medical College and Hospital of *Philadelphia, Wednesday, September 25-November 27, 1968.* Contact Paul J. Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Case-oriented Seminars on Psychiatry in Medical Practice;** by Staunton Clinic, at *Pittsburgh, Wednesday, September 18 and 19; Wednesday, December 18 and 19; Thursday, January 2-8, 1969;* fee \$100. Contact Charlotte M. Florine, M.D., Staunton Clinic, 3601 Fifth Ave., Pittsburgh 15213.

○ **Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *Philadelphia, Thursday, September 26-December 19 1968;* fee \$50; minimum number required 15, maximum permitted 30. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Graduate Applied Office Psychiatry;** by The Institute of the Pennsylvania Hospital, at *Philadelphia, Thursday, September 26-December 19, 1968;* fee \$50; minimum number required, 8, maximum permitted 15. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Medical Hypnosis;** by University of Pennsylvania, Department of Psychiatry, at The Institute of the Pennsylvania Hospital, *Philadelphia, Thursday, September 26-February 20, 1969;* fee \$250; maximum number permitted 45. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

SURGERY

○ **Surgery;** by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Thursday, September 5, 1968-May 15, 1969;* fee \$2150. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

○ **Surgical Anatomy and the Techniques of the Temporal Bone;** by University of Pittsburgh School of Medicine and Eye and Ear Hospital; *Pittsburgh, Sunday, September 15-21, Sunday, November 17-23, 1968.* Attendance limited to 13 physicians; fee \$500/week; contact Ralph J. Caparosa, M.D., 3600 Forbes Avenue, Pittsburgh 15213.

○ **Tumors of the Skin;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, *Wilkes-Barre, Wednesday, October 9, 1968.* Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

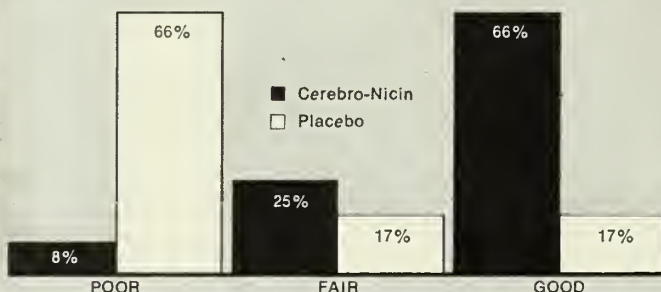
○ **Current Concepts of the Surgeon's Approach, Diagnosis and Treatment of Isolated Pulmonary Lesions;** by Jefferson Medical College and York Hospital; at *York, Thursday, October 17, 1968;* fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

For the treatment of the aging patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jr., of the Amer. Ger. Soc., June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylentetrazole.....	100 mg.
Nicotinic Acid.....	100 mg.
Ascorbic Acid.....	100 mg.
Thiamine HCl.....	25 mg.
L-Glutamic Acid.....	50 mg.
Niacinamide.....	5 mg.
Riboflavin.....	2 mg.
Pyridoxine.....	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylentetrazole although caution should be exercised when treating patients with a low convulsive threshold. Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.



Write for literature and samples...

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

in the treatment of
IMPOTENCE



Android®
(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID

GOOD TO EXCELLENT 75%

PLACEBO

20%

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths
Android

Each yellow tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . . 10 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . . 5.0 mg.
Thyroid Ext. (1/2 gr.) . . . 30 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.



Android-Plus

**WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C**
Each white tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/4 gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . . 250 mg.
Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate . . 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone 2.5 mg.
Ethynyl Estradiol 0.02 mg.
Thyroid Ext. (1/6 gr.) 10 mg.
Thiamine Hydrochloride . . . 10 mg.
Glutamic Acid 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, postoperative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA INDICATIONS:** See Android. Ethynyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

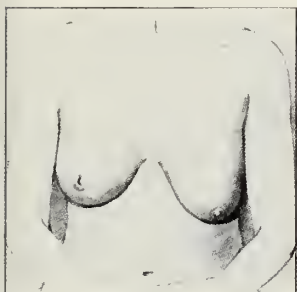
SAFEGUARD AGAINST BREAST CANCER

SYSTEMATIC EXAMINATION OF THE BREASTS SHOULD BE DONE:

In The Comprehensive Physical Exam

In Any Breast Complaint

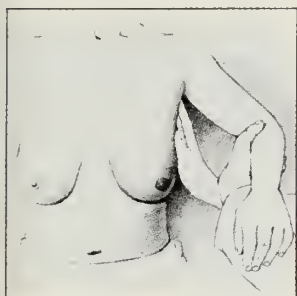
THE SOLITARY LUMP IS CANCER UNTIL YOU PROVE OTHERWISE



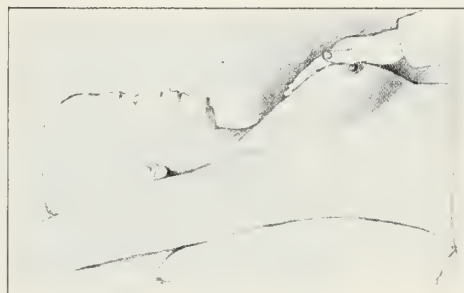
Observe The Undraped Breasts With Patient In Sitting Position, Hands In Lap.



Observe With Arms Upraised And Then Have Patient Clasp Hands In Front Of Her Face To Cause Pectoral Contraction.



Palpate The Axillae. Support The Arm With Your Arm.



Palpate Breast With Patient's Arm Up-raised. Use The Flat Of Your Hand.



Palpate Breast Again With Patient's Arm At Her Side.



28,000 WOMEN DIED IN 1967 FROM BREAST CANCER

DON'T "OBSERVE" THE BREAST LUMP - EXCISE IT

George P. Rosemond, M.D., Chief of Surgery, Temple School of Medicine Consultant

AMERICAN CANCER SOCIETY

PENNSYLVANIA DIVISION

PHILADELPHIA DIVISION

PENNSYLVANIA CANCER FORUM PAGE—presented cooperatively by the Council on Scientific Advancement of the Pennsylvania Medical Society, the Pennsylvania and Philadelphia Division of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health.

THE INSTITUTE OF THE PENNSYLVANIA HOSPITAL
PRESENTS A COURSE IN

APPLIED OFFICE PSYCHIATRY

BEGINNING SEPTEMBER 26, 1968

3:00 - 7:00 P.M., Thursdays
12 Weekly Afternoon Sessions
TUITION \$50.00

This course is open to all graduate physicians and consists of lectures, demonstrations, and practical work on basic concepts and clinical application designed to give the maximum useful information to the practicing physician who is interested in improving his ability to manage the psychiatric problems commonly encountered in the practice of medicine.

For further information contact:

Sydney E. Pulver, M.D., Course Director
The Institute of the Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa., 19139

THE INSTITUTE OF THE PENNSYLVANIA HOSPITAL
PRESENTS A COURSE IN

MEDICINE AND THE LAW

BEGINNING OCTOBER 9, 1968

1:00-3:00 P.M., Wednesday
10 Weekly Afternoon Sessions
TUITION: \$50.00

This Course is open to all graduate physicians and consists of lectures and discussion on legal questions of vital interest to the practicing physician. Doctor Jonas Robitscher, practicing psychiatrist and lawyer, will conduct the course.

For further information contact:

Sydney E. Pulver, M.D., Course Director
The Institute of the Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pennsylvania 19139

UNIVERSITY OF PENNSYLVANIA
DIVISION OF GRADUATE MEDICINE
SCHOOL OF MEDICINE

Presents a Course in

MEDICAL HYPNOSIS

BEGINNING SEPTEMBER 26, 1968

3:00 - 7:00 P.M., Thursdays

TUITION \$150

20 Weekly Afternoon Sessions

The course is open to all graduate physicians. It consists of lecture, demonstration, and supervised practical work in hypnosis totaling 80 hours.

For further information contact:

Office of the Director, Division of Graduate Medicine
237 Medical Laboratories
University of Pennsylvania
Philadelphia, Pa. 19104

*Easy on
the Budget...*

*Easy on
the Mother*

*Tablets & Elixir
For Iron Deficiency Anemia*

 BREON

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS
Fergon[®]
brand of FERROUS GLUCONATE



Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy.

Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.¹

*As shown by *in vitro* studies.

1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol[®]
phosphorated carbohydrate
solution
emesis control

★
Specialized Service

IN
PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

EASTERN PENNSYLVANIA OFFICE:

E. L. Edwards, D. R. Lowe, L. R. Wilson, Jr., and S. B. Elston, Jr., Representatives
Suite 126-BC, The Benson, Jenkintown 19046 Telephone: 215-887-6335

WESTERN PENNSYLVANIA OFFICE: N. Wells and S. T. Ingram, Representatives

1074 Greentree Road, Pittsburgh 15220 Telephone: 412-531-4226



⊙ Indicates membership in the Pennsylvania Medical Society at time of death.

⊙ **Earl A. Daugherty**, Philadelphia; Jefferson Medical College, 1930; age 65; died June 28, 1968. Dr. Daugherty was affiliated with Lankenau Hospital for thirty-three years. He was a Fellow of the Philadelphia and American Colleges of Physicians and the Heart Association of Southeastern Pennsylvania. Surviving are his wife and a son.

⊙ **Robert L. Ellis**, York; Jefferson Medical College, 1914; age 78; died June 26, 1968. Dr. Ellis was cited for pioneer work in intravenous and intraspinal diagnosis and therapy. He served in the Army Medical Corps during World War I and was past president of the York County Medical Society. His wife and two daughters survive.

⊙ **Samuel J. Glass, Jr.**, Pittsburgh; Johns Hopkins University School of Medicine, 1915; age 77; died June 22, 1968. Dr. Glass is survived by his wife.

⊙ **Henry Clemens Groff**, Philadelphia; University of Pennsylvania School of Medicine, 1902; age 92; died June 19, 1968. Dr. Groff was one of the first members of the staff of Temple University Hospital and founder of its x-ray department. Survivors include a son and a daughter.

⊙ **Anne Booth Heinbach**, Wyncote; Woman's Medical College, 1945; age 51; died June 17, 1968. Dr. Heinbach was formerly the director of pathology at the Medical Arts Laboratory in Philadelphia and was a member of the American Society of Clinical Pathologists and the Association for the Advancement of Science. Surviving are her mother and husband.

⊙ **Harry J. S. Keim**, Catasauqua; University of Pennsylvania School of Medicine, 1894; age 96; died June 12, 1968. Dr. Keim was a past president of the Lehigh County Medical Society. Survivors include a daughter, a son, a grandson and three great-grandchildren.

⊙ **V. James Kennedy**, Hazleton; Georgetown University School of Medicine, 1943; age 50; died June 14, 1968. Dr. Kennedy served as chair-

man of the Board of Directors, vice president and president of the Luzerne County Medical Society in recent years. Surviving are his wife, four children and six brothers.

⊙ **James P. Manly**, Scranton; Temple University School of Medicine, 1935; age 61; died July 2, 1968. Dr. Manly was formerly chief clinician at Scranton State Hospital Clinic and had served in the Army during World War II as a medical director at Walter Reed, Johns Hopkins and Ft. Hood Hospitals. Surviving are his wife, a daughter, a sister and several nieces and nephews.

⊙ **John M. Mustard**, Millersville; University of Ontario School of Medicine, 1924; age 70; died June 29, 1968. Dr. Mustard was a past-president of the Lancaster County Medical Society and served on the St. Joseph Hospital staff for forty years. Survivors include a son, three grandchildren, a brother and two sisters.

⊙ **Gerald E. Pratt**, Cherry Hill, N.J.; Jefferson Medical College, 1926; age 68; died June 24, 1968. Dr. Pratt is survived by his wife, a son and two grandchildren.

⊙ **Pasquale M. Vassalluzzo**, Feasterville; University of Rome School of Medicine, Italy, 1942; age 52; died July 4, 1968. Dr. Vassalluzzo was a member of the American Psychiatric Association. Surviving are his wife, his parents, two sons, two daughters, three brothers and three grandchildren.

⊙ **Robert B. Walker**, Browns Mills, N.J.; University of Pennsylvania School of Medicine, 1907; age 83; died April 30, 1968. Dr. Walker is survived by his wife.

⊙ **Vere K. Worster**, Waterford; Jefferson Medical College, 1920; age 73; died June 27, 1968. Surviving are two daughters and two sisters.

⊙ **Franklin C. Brush**, Phoenixville; University of Pennsylvania School of Medicine, 1916; age 78; died July 12, 1968. Dr. Brush was a member of the honorary staff of Phoenixville Hospital and a veteran of World War I. Surviving are his wife, a son, a daughter and five grandchildren.

F. Allen Rutherford, Lebanon; University of Pennsylvania School of Medicine, 1914; age 80; died June 30, 1968. Dr. Rutherford is survived by his wife, a son, a daughter and two grandchildren.

Charles C. Stauffer, Harrisburg; University of Pennsylvania School of Medicine, 1903; age 88; died June 15, 1968. Dr. Stauffer was a former member of the Board of Directors of the Harrisburg School District and a former director of Keystone Trust Co. Surviving are a son, two daughters, five grandchildren and two great-grandchildren.

⊙ **Francis E. DeLong**, Kutztown; University of Pennsylvania School of Medicine, 1906; age 87; died July 16, 1968. Dr. DeLong was a past-president of the Butler County Medical Society. He is survived by a sister and a brother.

⊙ **Pasquale J. D. Gambescia**, Philadelphia; Hahnemann Medical College, 1937; age 54; died July 9, 1968. Dr. Gambescia was a member of the faculty of Hahnemann and on the staffs of Hahnemann and St. Agnes hospitals. He was a member of the Philadelphia Pediatric Society and had served in the Navy Medical Corps in World War II as a lieutenant commander. He is survived by his wife, a son, a daughter, his mother, three sisters and a brother.

⊙ **Ruth Harral Freeman**, Drexel Hill; Cornell University Medical College, 1931; age 62; died July 7, 1968. Dr. Freeman was on the staff of Delaware County Memorial Hospital in the anesthesiology department. Surviving are her husband, a son, two sisters and three brothers.

⊙ **James M. Hincken**, Shamokin Dam; Hahnemann Medical College, 1903; age 86; died July 9, 1968. Surviving are his wife, two sons and a sister.

⊙ **Joseph H. Rissinger**, Enola; Temple University School of Medicine, 1929; age 67; died July 20, 1968. Dr. Rissinger was president of the People's Bank, Enola. Surviving are his wife and a sister.



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg; Dextromethorphan hydrobromide, 7.5 mg
A H Robins Company, Richmond, Virginia 23220

AH ROBINS

TEMPLE UNIVERSITY HEALTH SCIENCES CENTER

presents the 12th annual postgraduate course

RECENT ADVANCES IN MEDICINE

on 8 consecutive Wednesdays

from October 16th to December 4th, 1968,

from 11:00 a.m. to 4:00 p.m.

Aims of Course: Problems in Clinical Practice

Methods: Grand rounds, clinics, case discussions, office procedures, lectures and panel discussions, all with audience participation.

Faculty: Members of the Department of Medicine and other selected Departments of Temple University Health Sciences Center: Dr. Carl V. Moore, Washington University, St. Louis, Missouri and Dr. Donald C. Seldin, University of Texas, and other distinguished physicians from other medical schools.

For Further Information and Curriculum

DEPARTMENT OF MEDICINE

Temple University Health Sciences Center

3400 N. Broad Street

Philadelphia, Pennsylvania 19140

SOL SHERRY, M.D.

Chairman, Department of Medicine

ALBERT J. FINESTONE, M.D.

Director of Course



PENNSYLVANIA
MEDICINE

meetings

SEPTEMBER

Ninth International Congress of Neurology and the Fourth International Congress of Neurological Surgery, September 20-27, 1968, New York City.

PMS Board Meeting, September 25, 1968, Pittsburgh Hilton Hotel.

PMS House of Delegates, September 26-29, 1968, Pittsburgh Hilton Hotel.

Annual Fall Meeting of the Pennsylvania Chapter of the American Academy of Pediatrics, September 21-22, 1968, Allenberry-on-the-Yellow Breeches, Boiling Springs.

Sixth National Cancer Conference for physicians and allied scientists, September 18-20, 1968, Denver Hilton Hotel, Denver.

International College of Surgeons Congress (four meetings) beginning September 28, 1968 in Honolulu, Hawaii.

28th AMA Congress on Occupational Health, September 30-October 1, 1968, Waldorf Astoria Hotel, New York City.

Sixth National Cancer Conference, September 18-20, 1968, Denver, Colorado.

PMS Council on Public Service, September 14, 1968, PMS Headquarters, Lemoyne.

Second International Congress of the Transplantation Society, September 7-11, 1968, Americana Hotel, New York City.

OCTOBER

PMS Annual Scientific Sessions, October 27-29, 1968, Chatham Center, Pittsburgh.

Annual Session, American Society of Anesthesiologists, October 19-23, 1968, Washington, D.C.

Second National Congress on Medical Ethics, AMA Judicial Council, October 5-6, 1968, Drake Hotel, Chicago.

37th Annual Meeting, American Academy of Pediatrics, October 19-24, 1968, Chicago.

Tenth International Congress on Diseases of the Chest, October 4-8, 1968, Washington Hilton Hotel, Washington, D.C.

75th Convention, Association of Military Surgeons, October 21-23, 1968, Sheraton Park Hotel, Washington, D.C.

33rd Annual Meeting, Industrial Hygiene Foundation, October 15-16, 1968, Chatham Center, Pittsburgh.

American College of Obstetricians and Gynecologists District Meeting, October 17-19, 1968, Bellevue-Stratford Hotel, Philadelphia; October 16-18, 1968, Pittsburgh-Hilton Hotel, Pittsburgh.



PENNSYLVANIA MEDICINE

write now

Booklets: *Secrets for Stock Market Profits*, free on request when accompanied by a self-addressed envelope, from C. M. Whitmore, Jr., P.O. Box 1393, Evanston, Illinois 60204. . . *Catalog, The Pennsylvania State University College of Medicine*, gratis from the Office of Student Affairs, Milton S. Hershey Medical Center, 500 University Drive, Hershey, Pa. 17033. . . *Optimal Health Care for Mothers and Children: A National Priority*, available from the Information Office, National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, Maryland 20014. . . *A Study of Carbon Dioxide Gas Absorption*, available from the National Cylinder Gas division of Chemetron Corporation, 840 North Michigan Avenue, Chicago, Illinois 60611. . . *The Illness Called Alcoholism*, 20¢; *Marijuana and Society*, free; *The Best of Law and Medicine*, \$1.50; *Johnny Makes the Team*, 10¢; all from the American Medical Association, 535 North Dearborn, Chicago, Illinois 60610. . . *The Fitness Challenge in the Later Years*, free from the Administration on Aging, Room 3339, 330 Independence Avenue, S.W., Washington, D.C. 20201. . . *Cardiovascular Surgery*, 45¢ per copy from the Government Printing Office, Washington, D.C. 20402. . . *Current Research in Chronic Airways Obstruction*, \$2.00 per copy from the Government Printing Office, Washington, D.C. 20402. . . *Survey of Hospital Nursing Services*, \$4.00 from the National League for Nursing, 10 Columbus Circle, New York, N.Y. 10019.

FALL MEETING

Friday, September 13, 1968
Union League of Philadelphia
Broad and Sansom Streets
Philadelphia, Pa.

PROGRAM

GUEST SPEAKER

LYNDALL MOLTHAN, M.D., M.S.
Associate Professor Medicine and
Director of Blood Bank and Transfusion Service,
Temple University Health Sciences Center;
President, Pennsylvania Association of Blood Banks.

TOPIC

Autoimmune Hemolytic Anemia Complicating Ulcerative Colitis

SYMPOSIUM: Ulcerative Colitis (1 hour)

Moderator:	Harry E. Bacon, M.D.	Philadelphia
Participants:	Lyndall Molthan, M.D.	Wayne
	Herbert T. Hawthorne, M.D.	Bryn Mawr
	Robert J. Rowe, M.D.	Dallas
	J. Edwin Alford, M.D.	Buffalo
	Norman D. Nigro, M.D.	Detroit

SYMPOSIUM: (1 hour)

Anorectal Fistulas And Their Management

Moderator:	George L. Becker, M.D.	Paterson
Participants:	Patrick H. Hanley, M.D.	New Orleans
	Benjamin Haskell, M.D.	Philadelphia
	Andrew J. McAdams, M.D.	Pittsburgh
	William H. Ramsey, M.D.	Bryn Mawr
	Francis J. Burns, M.D.	St. Louis

Cocktails: 6:00 P.M. Dinner: 7:00 P.M.

Scientific Session: 8:00 P.M.

Frank H. Murray, M.D., Program Chairman
Harry E. Bacon, M.D., Co-chairman
Benjamin Haskell, M.D.

Kindly mail check to **Valentine R. Manning, Jr., M.D., 3336 Aldine Street, Philadelphia, Pa.**, for \$15.00 and made payable to the Pennsylvania Society of Colon and Rectal Surgery.

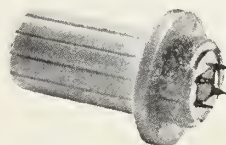
Robert A. McGregor, M.D., Secretary

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?

or

HISTO?

(Histoplasmosis — "The Masquerader")



A new aid in differential diagnosis HISTOPLASMIN, TINE TEST

(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).



Ask your representative for details or write Medical Advisory Dept.,
Lederle Laboratories, Pearl River, New York 10965. 406-8

ASSOCIATE EDITOR

THE MERCK MANUAL

We need an experienced MD Writer-Editor to assist in the preparation of this long-established handbook of diagnosis and therapy. This full-time position with an attractive future provides an excellent starting salary with liberal fringe benefits. Our Research Laboratories are located on spacious rural acreage, yet are convenient to the medical centers of Metropolitan Philadelphia. Please send summary of training and experience, date available and minimum salary expected to:



GORDON L. GERHARD
MERCK SHARP & DOHME
RESEARCH LABORATORIES

West Point, Pa. 19486

An Equal Opportunity Employer



PHYSICIANS WANTED

Attention: Physicians wishing to relocate and young physicians wishing to establish a rewarding practice in general medicine, internal medicine, obstetrics, gynecology, pediatrics, surgery, contact: A. W. MAYER, Administrator, The Titusville Hospital, Titusville, Pa. (814) 822-2291.

Physicians—part or full time. Student and Employee Health Service. Medical School hospital affiliation. Faculty appointment. Salary commensurate with qualifications. Submit curriculum vitae. P-31, P. O. Box 2066, Philadelphia, Pa. 19103. An equal opportunity employer.

Physician Wanted: Excellent opportunity for general practitioner, Emporium, Pa. County seat in northern area of State, center of hunting and fishing. Prosperous community, diversified industry, modern hospital facilities available. GP with large active practice retired, offices available. Contact EMPORIUM CHAMBER OF COMMERCE, 105 E. Fourth St., Emporium, Pa. 15834.

House Physicians—Limited openings for house officers available. Salary \$18,000 per year. 274-bed accredited general hospital. Must be eligible for or have licensure in Pennsylvania. Write: OFFICE OF ADMINISTRATOR, Lower Bucks Hospital, Bristol, Pa. 19007.

House physician for 202-bed general hospital, located in a growing university community, 55 miles from Pittsburgh. Rotate services with other house physicians. Pennsylvania license required. An excellent introduction to a community with good practice opportunities. Contact ADMINISTRATOR, Indiana Hospital, Indiana, Pa. 15701.

Wanted: Full time industrial physicians for permanent employment in du Pont Company plants in various states. Career positions. Excellent opportunity. General practitioners preferred. Salary open. Immediate openings. An equal opportunity employer—male/female. Call collect or write to: C. A. d'ALONZO, M.D., Medical Director, E. I. du Pont de Nemours and Company, 11400 Nemours Building, Wilmington, Delaware 19898. (302) 774-6234.

Emergency Room physicians needed for full-time staffing. Ideal for the new graduate or for the experienced physician wishing to slow down. Write ADMINISTRATOR, Sharon General Hospital, Sharon, Pa.

Internists, general practitioners, radiologists wanted to group medical practice in inter-city Philadelphia. Prefer those interested in social change. Competitive salary, fringe benefits and faculty appointment to medical school for qualified physicians. Please contact DR. HALE COOK, 3450 North 17th Street, Philadelphia, Pa. 19140.

House Physicians (3)—needed at 235-bed JCAH accredited short-term, general hospital in suburban Phila. Established educational program and residency in general surgery. \$13,500 per annum plus benefits. Excellent practice opportunity in growing area. Pa. License required. Contact: BRUCE R. MARGER, M.D., Sacred Heart Hospital, 1430 DeKalb St., Norristown, Pa. 19401.

Young G.P. Partnership—desires to add third man. Solo practice opportunities also available. Small town, excellent environment for raising family. New high school. 130-bed hospital. Challenging inpatient service averaging 25 to 30 patients. OB optional. College, industry, nursing home, school, and emergency room work available, plus guaranteed busy office practice. Visit at our expense. Contact GORDON R. JONES, M.D., Greene County Memorial Hospital, Waynesburg, Pa. 15370. Phone (412) 627-3101.

Cardiologist—To be available immediately, Charleroi-Monessen Hospital, North Charleroi, Pa., 15022. Must be Board certified or Board eligible in cardiology, or must be Board certified or Board eligible in internal medicine with at least one additional year of formal training in cardiology. Primary duties to serve as chief of the department of cardiology and director of the coronary intensive care unit presently under development. Hospital consists of 211 beds plus 24 bassinets and is in a developmental expansion program. The present volume of electrocardiograms is 4,500 per year. Terms open. The hospital will defray up to ½ the expense for personal interview. Direct all responses to the Administrator.

General Practitioners: We Need You. Beautiful, progressive community of Zelienople, located just 30 minutes north of Pittsburgh. Market area of 10,000. Excellent facilities, Assistance available. T. R. MURRAY, Zelienople Area Jaycees, Box 35, Zelienople 16063.

Medical Director—The Fidelity Mutual Life Insurance Company of Philadelphia has an opening for an Assistant or Associate Medical Director. You may write on a confidential basis or call DR. VAUGHAN P. SIMMONS, PO 5-6500.

Attractive opening with The Pennsylvania State University for qualified psychiatrist interested in challenge of increased need for expansion of services to University undergraduate and graduate students. Dynamic progressive program. Opportunity for teaching experience. Many liberal benefits, including educational privileges for your family. Healthful mountain community with excellent hunting, fishing, camping, and other recreational facilities. For more information, contact: JOHN A. HARGLEROD, M.D., Director, University Health Services, Ritenour Health Center, University Park, Pa. 16802. An Equal Opportunity Employer.

Psychiatrist or physician—accredited hospital. Approved psychiatric residency program, affiliated with approved general hospital. \$14,657 to \$22,768; maintenance arrangements possible. Pennsylvania license required. R. L. GATSKI, M.D., Superintendent, State Hospital, Danville, Pa.

Associate—General practitioner, young, to join two general practitioners in central Pennsylvania. Modern office, good hospital facilities. Salary first year then partnership. No expenses. Write Department 526, PENNSYLVANIA MEDICINE.

Internist, boarded or eligible, needed to establish own practice. Registered Pa. Service area 65,000. Two other internists. Appointment available 207-bed JCAH approved modern hospital. All services covered by specialists. Communicate ADMINISTRATOR, Lewistown Hospital, Lewistown, Pa. 17044.

classified

Physician for Student Health Service. Easy hours, pleasant work, excellent fringe benefits. Contact H. C. PIEPER, M.D., Director, University Health Service, Lehigh University, Bethlehem, Pa. 18015. An equal opportunity employer.

Psychiatric Residencies—Norristown State Hospital. First, second and third year openings available in modern, dynamic training center with broad eclectic program which includes comprehensive community psychiatry, forensic, alcoholic, group and family treatment, geriatric, adolescent, adult, acute, day and night treatment centers. Medical school affiliations and others for psychophysiological psychiatry and intensive individual child adolescent and adult out-patient therapy, psychoanalytical oriented, thirty minutes from cultural Philadelphia; beautiful progressive suburban area, unlimited opportunities for practice. Housing and maintenance available. Salaries for licensed physicians begin \$10,954; unlicensed \$8,580. Call or write DIRECTOR OF TRAINING AND EDUCATION, Norristown State Hospital, Norristown, Pa. (215) 275-9700.

Emergency Room Physician—Full time. Accredited 300-bed general hospital; affiliated with the Guthrie Clinic; active internship and residency program; excellent benefits. Located in northeastern Pennsylvania, 20 miles east of Elmira, N.Y. ROBERT PACKER HOSPITAL, Sayre, Pa. 18840. (717) 883-9251, ext. 262.

Associate Radiologist—Board Certified or qualified, to be member of a three man group. General community hospital in southwestern Pennsylvania. Liberal income. Write Department 531, PENNSYLVANIA MEDICINE.

Associate Radiologist to be available July 1, 1968, Charleroi-Monessen Hospital, North Charleroi, Pa. 15022. Must be Board Certified or Board Eligible, American College of Radiology. Primary duties to assist chief radiologist. Hospital consists of 211 beds plus 24 bassinets and is in a developmental-expansion program. The Department consists of 6 registered technicians plus ancillary personnel. Salary: \$25,000 per year minimum—negotiable. Liberal fringe benefits including 30 days annual vacation and sick leave plus 14 days per year to attend educational meetings. The hospital will defray up to ½ the expense for personal interview. Direct all responses to the ADMINISTRATOR.

Psychiatric residency training—2 year approved, third year in University connected Psychiatric Institute. \$8,580 to \$12,075; maintenance arrangements possible. ECFMG and/or license acceptable in Pennsylvania re-

quired. R. L. GATSKI, M.D., Superintendent, Danville State Hospital, Danville, Pa. 17821.

PRACTICE AVAILABLE

General Practice—for sale, Central Bucks County, Pa., active, acute, no OB, good coverage, open staffed hospitals, excellent gross, will introduce, inquiries invited. DANIEL A. NESI, M.D., 202 N. Main St., Chalfont, Pa. 18914.

OFFICES AVAILABLE

General Practitioners—Rent-free air conditioned offices for first year. Centrally located with adequate parking. Beautiful resort area in southcentral Pennsylvania. Bedford offers an excellent practice opportunity. Small town; friendly surroundings with no big city problems. Write giving all particulars to P.O. Box 162; Bedford, Pa. 15522.

CLASSIFIED ADVERTISING INFORMATION

RATES—\$10.00 per insertion up to 30 words; 40 cents each additional word; \$1.00 per insertion for answers sent in care of Pennsylvania Medical Society. Payable in advance.

COPY DEADLINE—Copy due by the first day of month preceding month of publication. Send to Pennsylvania Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pennsylvania 17043. The right is reserved to reject or modify copy to conform with publication rules.

DEPARTMENT NUMBERS—Advertisers using department numbers forbid disclosure of their identity. Written inquiries are forwarded to such advertisers.

WORD COUNT—Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one, and "Write Department . . ., Pennsylvania Medicine," as five.

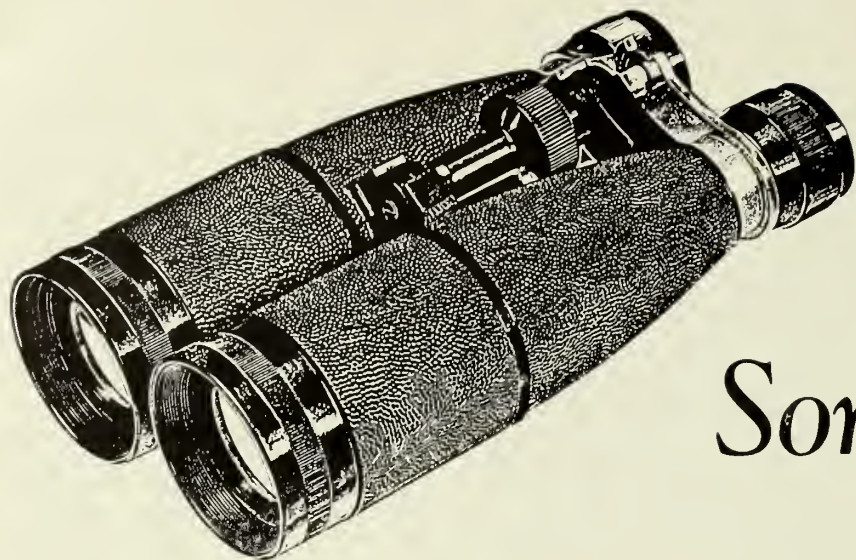
THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA

FOUNDED 1824: A chartered university since 1838. Coeducational 1961.

FACILITIES: Jefferson Hall contains modern well-equipped laboratories, the Daniel Baugh Institute of Anatomy, and a student-faculty activities center; Jefferson Medical College Hospital; Curtis Clinic—an outpatient center; Barton Memorial Division of Chest Diseases; teaching museums and libraries; and instruction privileges in sixteen other hospitals.

ADMISSION: For full particulars regarding admission requirements write to Samuel S. Conly, Jr., M.D., Associate Dean and Director of Admissions, 1025 Walnut St., Philadelphia, Pa. 19107.

WILLIAM F. KELLOW, M.D.
Dean and Vice President



Looking for Something?

Try PENNSYLVANIA MEDICAL SOCIETY PHYSICIAN PLACEMENT SERVICE



EDUCATION

ALBERT EINSTEIN MEDICAL CENTER

ANNOUNCES A POSTGRADUATE COURSE IN

ALLERGIC PRACTICE

PHILIP M. GOTTLIEB, M.D.

SAMUEL E. RYNES, M.D.

Co-Directors

At Its

NORTHERN DIVISION

ON

THURSDAY AFTERNOONS

From 2 to 5 P.M.

September 19, 1968

through November 21, 1968

This course is oriented toward the practicing physician in its emphasis on the clinical aspects and practical management of the common allergic diseases. The initial sessions will include sufficient of the relevant principles of the pertinent basic sciences to provide a foundation for the clinical approach. This will be supplemented by demonstrations illustrating the latest serologic, immunologic and diagnostic techniques.

In the latter weeks, the registrants will be divided into small groups for detailed analysis of cases and review of the clinical course and management of patients under active treatment. While primary attention will be centered on diagnostic and therapeutic procedures in ambulatory allergic patients, hospitalized cases will be studied, as available. The balance of each afternoon will be devoted to informal panel discussions of the principal allergic manifestations. There will be ample opportunity for student participation and questions.

This course will be given on 10 consecutive Thursdays. The course is acceptable for 30 hours of credit by the American Academy of General Practice Category I. Limited registration of 25 students closes September 5, 1968.

For brochure and application form, write to:

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION
ALBERT EINSTEIN MEDICAL CENTER
York and Tabor Roads
Philadelphia, Pennsylvania 19141



EDUCATION

ALBERT EINSTEIN MEDICAL CENTER

ANNOUNCES A POSTGRADUATE COURSE IN

BASIC ELECTROCARDIOGRAPHY

SOLOMON S. MINTZ, M.D.

Director

HERBERT W. COPELAN, M.D.

Co-Director

At Its

SOUTHERN DIVISION

ON

WEDNESDAY AFTERNOONS

From 1 to 4 P.M.

September 25, 1968

through January 8, 1969

(excluding December 25, 1968, and January 1, 1969)

This is a comprehensive course covering the basic principles of electrocardiography and the various types of electrocardiographic alterations that follow disease processes. The schedule has been arranged so that two hours of practical electrocardiographic demonstration and interpretations follow the didactic lecture. The subject matter of a didactic lecture may be further discussed and illustrated by slide demonstrations. A brief question and answer period, related to the subjects covered during the afternoon, will conclude each session.

This course is presented in 14 sessions of three hours each. Registration is limited to 30 students, and closes September 11, 1968. The fee is \$75.00. This program is acceptable for 42 hours of Credit by the American Academy of General Practice.

For brochures and application form, write to:

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION
ALBERT EINSTEIN MEDICAL CENTER
York and Tabor Roads
Philadelphia, Pennsylvania 19141



"How can the State Society communicate better with physicians?"

Dear Sir:

Pennsylvania physicians will pay attention to their medical societies only if they think those societies have something important to say or do. Gaining attention is easier than holding it.

There are two attention-holding devices available to our state society which are worthwhile, and one which probably isn't.

PENNSYLVANIA MEDICINE has improved vastly in its new format, but it still is a bastard publication. It cannot be a record of minutes of official meetings, a journal of scientific articles, a newsletter of current events or a bulletin of announcements at one-and-the-same time. It has a gorgeous new dress, but hasn't decided where its going to go.

The Officers' Convention was a fine idea, and still is. But I see no reason why an expensive, full-dress convention, every two or three years should not reach more people, at less cost, with more information and ideas, than are produced by our present pallid annual Officers Convention.

I therefore suggest that the long-range aims of PENNSYLVANIA MEDICINE be re-examined and that the large-scale Officers Convention of former years be resumed on a biennial or triennial basis for the sake of freshness and economy.

BRUCE H. CARNEY, M.D.
Norristown

Dear Sir:

The rapidity with which today's world progresses makes communication necessary but difficult. The need is for rapid transmittal of important information in a simple concise form directly to the user—in this instance the physician. Society journals and magazines, because of their fixed date of issue, lose the element of speed. A variety of solutions is needed. Closer and more frequent communication between a State and County society should help. A well organized News Report or Resume issued directly to the doctor at frequent intervals as the need for communication develops should solve the urgency. State and County magazines should continue to present less immediate information.

DONALD C. GEIST, M.D.
Philadelphia

Dear Sir:

The question is ambiguous. Communicate what? To which physicians? By what medium? Certainly the med-

ium should be suited to the message and its intended audience. If one wishes to make certain the message has been understood as well as received, person to person contact is ideal; the telephone second best. Particular circumstances should dictate the choice among telegram, personal letter and newsletter. The obvious choice when the entire state society or large segments of it are being addressed is PENNSYLVANIA MEDICINE. But the effectiveness of the journal is diminished by the noisy, distracting advertisements which strut through its pages from front to back without deference to any portion. In my opinion the communicatory appeal and effectiveness of PENNSYLVANIA MEDICINE would be greatly enhanced if the advertisements were confined to the "wings" as in most other respectable medical journals.

MARIO N. FABI, M.D.
Scranton

Dear Sir:

In my opinion, the PMS is facing grave difficulties when it tries to communicate better with physicians. This is not because of any innate lack of merit in the State Society, but merely because most physicians, fortunately, have been trained to take care of sick people, and have little time for anything else. One does not relax from a busy medical practice by conning committee, commission and council reports. It is also hard for a tired M.D. to respond favorably to appeals to duty, creeping menaces to the contrary notwithstanding.

I consider this problem basically insoluble. It will be ameliorated when, and if, we have a more adequate supply of doctors. It can also be ameliorated by resort to more small, quickly readable materials. If the drug houses can do it, so can we. I think we should consider discontinuing the Journal and putting this money to use elsewhere. It is a serious step, but I think it should be seriously considered. I think the Society should have "detailmen" functioning similarly to others with whom we are all familiar. It is obvious that less than thirty percent of doctors regularly attend Society meetings. The mountain must go to Mohammed. I wonder if the Annual Meeting should not be replaced by ten or twelve, or twenty or thirty, regional meetings, preferably held in local hospitals.

Ideally, every doctor in Pennsylvania, member or not, should see a representative of the PMS once a year. I suppose that's enough iconoclasm for one day.

ERNEST L. ABERNATHY, M.D.
Washington, Pa.

Dear Sir:

Today failure in communication is a universal plague. Between our own State Medical Society and its members it can, in my opinion, be improved by making the following changes:

1. PENNSYLVANIA MEDICINE like many medical journals, is too formidable. It should be used only for scientific reports, long editorials and possibly a feature.

2. A weekly "newsletter" with short bursts of news in capsule form, presented brightly, arriving on the doctors desk NOT in an envelope, will be read. Gradually after this barrage, the "image" of the Pennsylvania State Medical Society will come through and there will be the "sense of belonging" that is presently lacking.

PAUL K. STOLTZ, M.D.
Berks County

Dear Sir:

The Pennsylvania Medical Society can improve communications with physicians by formally and informally soliciting from the physicians and the County Medical Societies controversial and complex issues before them. It could then relate the experience of other physicians and communities with these issues and the consequences of alternative experiences. This could be done without bureaucratic infringement upon the autonomy of the County Medical Society or the independence of the physician. The Pennsylvania Medical Society is free of colloquial, vested interests, has broad experience and talented personnel, and could offer unbiased and unemotional objective advice. The Pennsylvania Medical Society would thereby demonstrate its interest in serving the County Medical Societies and physicians, and if its advice proved worthy, it would receive the unqualified support of the recipients.

THEODORE L. DONMOYER, M.D.
Allentown

Advertiser's Index

Abbott Laboratories	28, 29, 30, 141, 142, 143, 144, 3rd Cover
Albert Einstein Medical Center	138
Ayerst Laboratories	14, 15
Breon Laboratories	131
The Brown Pharmaceutical Co.	128
Burroughs-Wellcome	59
Campbell Soup Company	79
The Dow Chemical Company	44
Geigy Pharmaceuticals	12, 13, 62, 63
Hynson, Westcott & Dunning	1
Jefferson Medical College	137
Lederle Laboratories	3, 17, 18, 19, 20, 23, 25, 42, 46, 47, 135
Lilly, Eli and Company	4, 5, 6, 50, 82, 120, 121
Medical Protective Co.	132
Merck, Sharp & Dohme	49, 135
The National Drug Co.	31
Obetrol Pharmaceuticals	32
Parke, Davis & Company	41
Pennsylvania Hospital	130, 131
Pennsylvania Society of Colon and Rectal Surgery	135
Philips-Roxane Laboratories	64, 65
Pitman-Moore	35
Poythress, Wm. P. & Co., Inc.	24
Robins, A. H. Co., Inc.	83, 84, 119, 134
Roche Laboratories	21, 60, 61, 4th Cover
Roerig, J. B. & Company	38, 39
Rorer, Wm. H., Inc.	25, 132
Sandoz Pharmaceuticals	40
Searle, G. D. & Co.	80, 81
Smith Kline & French Laboratories	125
Strasenburg Pharmaceuticals	37
The Stuart Company	122
Temple University	134
Vale Chemical Company	22
Warner Chilcott Laboratories	85, 86
Wyeth Laboratories	11, 123, 124

Abbott Antihypertensive Building Blocks

A simplified approach
to the practical management
of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

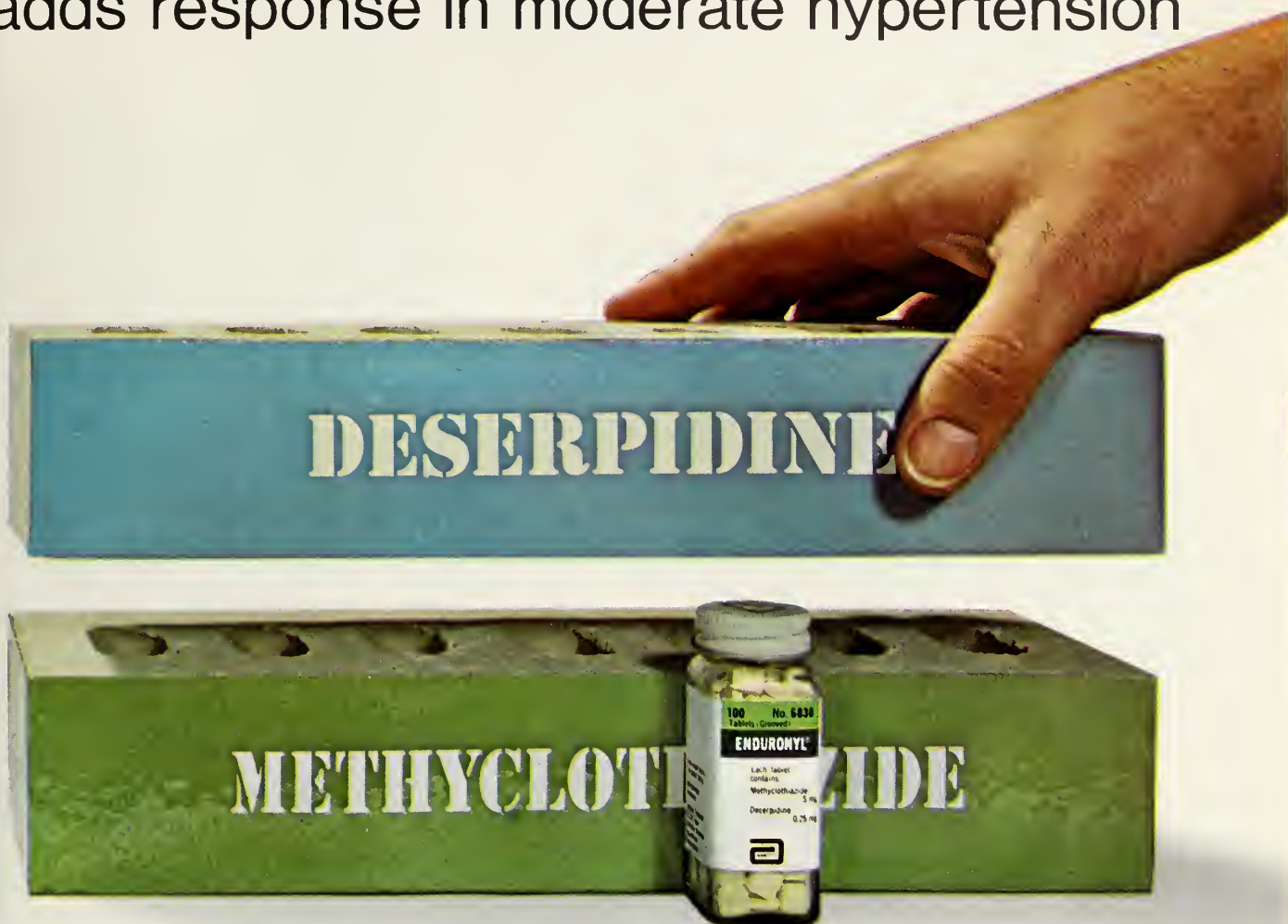
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

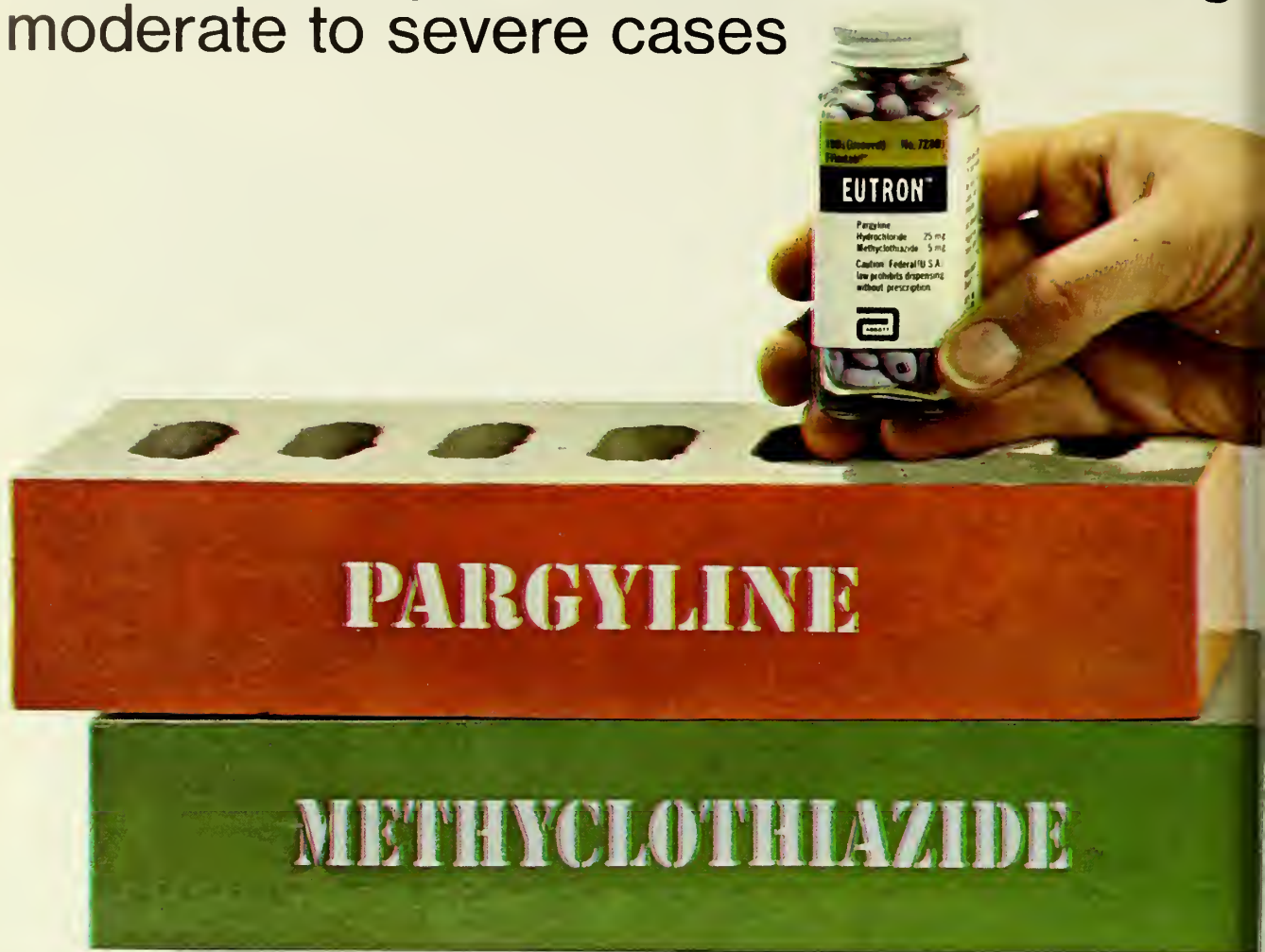
ENDURONYL[®]

METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON[®] | ENDURONYL[®]

METHYLOTHIAZIDE

Each tablet contains
Methylothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symptomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON[™]

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methylothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhib-

itors; methyl dopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methylothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methylothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug.

804438R



Whenever anxiety induces or intensifies clinical symptoms

Librium®

(chlordiazepoxide HCl)

*Quickly relieves anxiety~Helps improve response in
psychophysiologic disorders~Seldom impairs
mental acuity or physical coordination, on proper dosage~
Has wide margin of safety*

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

10 SEP 1968

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing

gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly

and debilitated. These are reversible in most instances by proper dosage adjustment, but also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche®

LABORATORIES

Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Also available: Libritabs™ (chlordiazepoxide) 5-mg, 10-mg, 25-mg tabs

PENNSYLVANIA MEDICINE

OCTOBER 1968

FRANCIS & TAYLOR
LIBRARY OF MEDICINE



George E. Farrar, Jr., M.D.

119th PRESIDENT-PENNSYLVANIA MEDICAL SOCIETY

HEALTH MANPOWER

OCCIPITAL NEURALGIA

X EXCHANGE OFFICE
FRANCIS & TAYLOR
MED-10 SHATTUCK ST
BOSTON MASS 02115

For those who have
the compulsion to
mend a broken
body

THERE'S A PLACE FOR EVERY QUALIFIED STUDENT IN HEALTH

the compassion to
salve a tormented
mind . . . or the
imagination to seek
the secrets of life
in a drop of blood

NO MATTER WHICH HEALTH FIELD STUDENTS CHOOSE, THEY WILL ENCOUNTER

the pulse of life . . .

Doctor, you can help fill the
accelerating demands for
expanding health care services

THEY WILL
MEASURE IT
IDENTIFY IT
TIME IT
PHOTOGRAPH IT
RECORD IT
STIMULATE IT
EMULATE IT
STRENGTHEN IT
PRESERVE IT

**SUPPORT THE MEDICAL STUDENT RECRUITMENT
PROGRAM OF THE PENNSYLVANIA MED-
ICAL SOCIETY AND THE MEDICAL EX-
PLORER PROGRAMS OF THE BOY SCOUTS
OF AMERICA**



WRITE TO THE P.M.S. COUNCIL ON PUBLIC SERVICE FOR ALL THE DETAILS

PENNSYLVANIA
MEDICINE

medigram

OCTOBER, 1968



1968 Pennsylvania Medical Society House of Delegates in Session

PITTSBURGH SESSION IN BRIEF

More than 500 persons participated in the 119th annual session of the Pennsylvania Medical Society House of Delegates and in the Woman's Auxiliary convention in the Pittsburgh Hilton, September 26-28, 1968. The House took many important actions, including several that may prove to be historic, and wound up its business on Saturday afternoon without need for a Sunday morning session. The House passed a resolution memorializing Joseph A. Walsh, M.D., of Blakely-Olyphant, a member of the Board of Trustees, who died September 24. The delegates chose Carl B. Lechner, M.D., of Erie, as President-Elect and George E. Farrar, Jr., M.D., of Philadelphia, was elevated to the Presidency to succeed John H. Harris, Sr., M.D., of Harrisburg. The Pennsylvania Medical Golfing Association held a tournament Monday, September 30, and art exhibits were presented by the Physicians Art Association.

PMS DUES REMAIN \$75

The House of Delegates approved retaining the current \$75 annual dues for active membership in the State Society and allocated \$8 from each active member's dues to the Educational Fund of the Educational and Scientific Trust and \$1 per active member to the Medical Benevolence Fund. The recommendation for retention of the current dues was made by the Finance Committee Chairman who noted that the House-directed expansion of State Society activities is bringing closer the day when activities will have to be decreased or the dues figure increased.

DR. LECHNER PRESIDENT-ELECT:
DR. SHIELDS NEW BOARD MEMBER

of the Pennsylvania Medical Society in one of a series of important elections as part of the annual meeting of the State Society House of Delegates in the Pittsburgh Hilton.



Carl B. Lechner, M.D.

Carl B. Lechner, M.D., of Erie, Medical Editor of Pennsylvania Medicine, was unanimously named President-Elect

The delegates chose Dr. Lechner to succeed to the presidency a year from now in the tradition of electing their top officer a year in advance. He's a specialist in radiology and practices in several Erie hospitals, including St. Vincent where he was an elevator boy as a youth. Later the same day, September 28, George E. Farrar, Jr., M.D., of Philadelphia, was elevated to the presidency, succeeding John H. Harris, Sr., M.D., of Harrisburg.

unexpired term of the late Joseph A. Walsh, M.D., of Blakely-Olyphant, who died September 24. George A. Rowland, M.D., of Millville, and David S. Masland, M.D., of Carlisle, were re-elected to five-year terms on the Board.

John B. Montgomery, M.D., of Philadelphia, was elected to the PMS Judicial Council, the "high court" of Pennsylvania medicine.

In other voting, the delegates from the state's component county medical societies re-elected Allen W. Cowley, M.D., of Harrisburg, as secretary and chose four vice-presidents. They are Charles K. Rose, Jr., M.D., of Allentown, First Vice-President; Orlo G. McCoy, M.D., of Canton, Pa., Second Vice-President; Charles A. Bikle, M.D., of Chambersburg, Third Vice-President; and LeRoy A. Gehris, M.D., of Reading, Fourth Vice-President.

William Y. Rial, M.D., of Swarthmore, was re-elected Speaker of the House of Delegates and John B. Lovette, M.D., of Johnstown, was re-elected Vice-Speaker.

Six were elected to serve two-year terms as delegates to the American Medical Association. They are William A. Barrett, M.D., of Pittsburgh; Park M. Horton, M.D., of New Milford; Edmund L. Housel, M.D., of Philadelphia; William A. Limberger, M.D., of West Chester; William Y. Rial, M.D., of Swarthmore; and William B. West, M.D., of Huntingdon. Six alternate delegates also were elected to two-year terms. They are A. Reynolds Crane, M.D., and Malcolm W. Miller, M.D., of Philadel

phia; Leo C. Eddinger, M.D., of Allentown; Raymond C. Grandon, M.D., of Harrisburg; John B. Lovette, M.D., of Johnstown; and George A. Rowland, M.D., of Millville. Three alternates were elected for one-year terms-- Paul S. Friedman, M.D., of Philadelphia; John F. Hartman, M.D., of Erie; and Matthew Marshall, M.D., of Pittsburgh.

Edgar W. Meiser, M.D., of Lancaster, was elected to the Committee to Nominate Delegates and Alternates to the AMA.

District censors were elected as nominated by each county and as published in the Official Reports Booklet, with the exception that E. F. Conlin, M.D., of Sharon, replaced G. H. Diehl, M.D., of Greenville, for Mercer County.

SPECIALTY DELEGATES DENIED The PMS House postponed indefinitely a resolution and a recommendation aimed at establishing House representation for recognized State Specialty groups.

SPECIALTY GROUPS INVITED TO USE PMS OFFICES The Board of Trustees has opened the door to providing administrative services in the headquarters building to state specialty societies in return for appropriate reimbursement from the societies to cover the costs. The action was taken at the Board's reorganization meeting following adjournment of the House which had directed the Board to explore ways of channeling the efforts of the State Society and of specialty and sub-specialty organizations into a more cooperative and mutually beneficial program. The Pennsylvania Psychiatric Society is exploring such an administrative arrangement with the State Society and the Board feels such arrangements would be beneficial in maintaining a closer relationship between the State Society and the specialty groups.

USUAL PENNSYCARE FEES SUPPORTED The House of Delegates directed the State Society to continue to work for the establishment of usual and customary fees for physician services provided for Pennsycare (Title XIX) patients. The action was taken in approving a resolution (68-1) from the Chester County Medical Society. The resolution noted that "the usual and customary fee concept has always been an integral part of sound professional practice" and that such a concept is the only proper basis for continued highest quality care for all people. It pointed out that this concept has been accepted by the federal government as a basis for payment under Medicare.

SEPARATE SESSIONS APPROVED The House of Delegates changed the State Society Constitution and Bylaws to continue the separation of business and scientific sessions as established by the House last year.

PREVAILING FEE APPROVED

The PMS House of Delegates urged Blue Shield to take all necessary steps to offer the prevailing fee program to presently enrolled and prospective group and non-group subscribers throughout the state "at the earliest opportunity." The approved reference committee report noted that the Blue Shield prevailing fee program for sale to the general public was approved by the Blue Shield Board in September and that the program requires the approval of the State Insurance Commissioner. Such approval will be sought about November 1, 1968.

EDUCATION EFFORTS ASSIGNED:

NEW COUNCIL PLAN DEFEATED

The proposal to establish a new Council on Education was rejected by the House of Delegates and the total educational responsibilities were reassigned to the Council on Scientific Advancement, which has been renamed the Council on Education and Science. In related actions, the Committee on Convention Program was abolished and its responsibilities were assigned to the Council on Education and Science, with the Council chairman or a delegated substitute presiding at scientific assemblies.

In considering the proposed establishment of a new Council on Education, the Reference Committee said testimony indicated agreement on the need for consolidation of the Society's educational activities under one administrative unit. The disagreement occurred on whether a new administrative unit should be established to handle these responsibilities, or whether they could be best handled by an existing council. The Reference Committee said that an existing council would be able to move rapidly toward achievement of the educational goals and that the Council on Scientific Advancement already was deeply involved in continuing medical education and is seeking funds to support educational programs. In a related comment, the House said that the Council on Education and Science should be aware that its primary responsibility is continuing medical education and that this primary responsibility should not be permitted to take second place to any other. The new definition of the Council on Education and Science is as follows: "...shall be responsible for all matters relating to continuing medical education, the extension of medical knowledge, and the advancement of medical science."

Subsequently, the Board of Trustees expanded the membership of the Council on Education and Science by five and the additional appointments will be made by the State Society President, George E. Farrar, Jr., M.D.

OFFICERS' CONFERENCE TO CONTINUE

The House of Delegates supported a Board of Trustees' decision to continue the annual spring Officers' Conference. A proposal had been made to the Board to abolish the Officers' Conference in favor of expanded Councilor District meetings.



Dr. Walsh

DR. WALSH SUCCUMBS TO ILLNESS

Proclaiming his death on Sept. 24 as a "great loss" the PMS House of Delegates eulogized Joseph A. Walsh, M.D., Trustee and Councilor of the Third Councilor District and Chairman of the PMS Publication Committee, with a memorial resolution that cited him for being "a dedicated and very active physician, giving freely of himself and earning the respect of his friends, his neighbors, his patients and his colleagues, who remember his outstanding leadership in his profession and in his community..."

RELICENSING STUDY APPROVED

The House "approved in principle and referred for additional study recommendations made by Dr. Farrar concerning alternatives to the growing pressure for the periodic relicensing of physicians. Dr. Farrar's recommendation was for the exploration of the possibility of periodic relicensing of physicians and other health professionals with such relicensure granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty. He suggested that the American Academy of General Practice educational requirements for continuing membership might serve as a model for the development of a plan to apply to all physicians in the state.

CONCURRENT, CONSECUTIVE CARE URGED

The House of Delegates urged Pennsylvania Blue Shield to provide comprehensive concurrent and consecutive care provisions in all of its subscriber agreements to cover deficiencies in the present plans. Such coverage would allow the frequently encountered instances when, for example, a diabetic patient admitted for surgery requires not only the attention of the surgeon but general medical supervision of the diabetes.

MEDICINE, OSTEOPATHY SURVEY ASKED

The House of Delegates, noting that no significant progress has been made in the proposed union of medicine and osteopathy in the past year, directed that county medical societies be surveyed to determine what they feel should be done to promote the proposed merger. The House asked that the survey results be reported at the next annual session.

ADVISOR PLAN REFERRED

The House referred to the Board of Trustees for action a recommendation made by George E. Farrar, Jr., M.D., in his speech as President-Elect, which called for the appointment of a committee of seven prominent laymen to advise the State Society in evaluating the social and economic aspect of health care in the state.

TRIBUTE TO A LADY

The PMS House of Delegates extended an affectionate tribute to M. Louise C. Gloeckner, M.D., of Conshohocken, exemplified by a bouquet of roses and a kiss from the House Speaker, William Y. Rial, M.D., of Swarthmore. Dr. Gloeckner, the first woman to serve in the AMA House of Delegates and a member of the PMS House since 1944, announced her retirement from the AMA House at the end of the year and her intention to retire from the PMS House where she has served as Chairman of the Reference Committee on Constitution and Bylaws for many years. In addition to the roses and the kiss, the House gave her a standing ovation.



Dr. Gloeckner and Dr. Rial

BOARD MEMBERS ADDED

The House of Delegates has added its Speaker and Vice-Speaker to the Board of Trustees and Councilors as ex-officio members without the right to vote. Last year, the House had suggested that the Constitution and Bylaws be changed to add the Speaker and Vice-Speaker to the Board with the right to vote but the proposed amendments were changed to eliminate the voting right. In addition to the District Councilors, the voting members of the Board include the President, President-Elect and Immediate Past President of the Society.

DISASTER MEDICINE TRANSFERRED

The House of Delegates has consolidated all of the State Society emergency medical service responsibilities under the Council on Education and Science and in so doing removed from the Council on Public Service the activities of its Commission on Disaster Medical Care. The broader term of "emergency medical services" includes all degrees of such service from meeting the emergency needs of an individual to responding to a broad disaster.

PMS BOARD REORGANIZES

In its reorganization meeting immediately following the House session, the PMS Board of Trustees re-elected William A. Limberger, M.D., of West Chester, as Chairman and elected David S. Masland, M.D., of Carlisle, as Vice-Chairman. The Board reappointed Carl B. Lechner, M.D., of

Erie, as Medical Editor of "Pennsylvania Medicine" and renamed Pepper, Hamilton & Scheetz of Philadelphia as the Society's legal counsel. Mr. Lester H. Perry was re-elected Treasurer.

MANPOWER STUDIES SUPPORTED

The PMS House of Delegates approved the State Society continuing studies in the development of ancillary medical manpower and directed that future studies take into consideration the recommendations in the address of the President-Elect, Dr. Farrar. The related remarks of Dr. Farrar were as follows: "To aid us in providing the health care the American people are expecting, we must enlist and make effective the help of the allied health professions. I recommend that the appropriate State Society bodies study the use of allied health professionals, including their educational qualifications, criteria for certification by the state of Pennsylvania, and their legal responsibility in the provision of health care. Many highly trained but incompletely educated medical corpsmen are being discharged from our armed services. We need this health manpower very badly. The aid of the colleges of Pennsylvania should be sought to qualify these veterans for a specific role in the health team and the criteria for certification of this group by the State Board of Medical Education and Licensure needs attention."

PMS USE OF FEDERAL FUNDS APPROVED IN HOUSE ACTION

The PMS House of Delegates, in endorsing recommendations made by the President and President-Elect, advised the Board of Trustees to solicit and use at its discretion private and/or governmental financial support as needed and authorized the Board to establish a new corporation if and when needed to handle such funds.

The approved Reference Committee comments were as follows: "Your committee gave careful consideration to the concept of the Society using federal funds. The committee noted that the Educational and Scientific Trust has projects which have remained only in the planning stage because it has not been authorized to seek federal grant monies. The committee also noted that federal grants are available to assist the appropriate unit in the responsibilities of continuing education. The Reference Committee is also aware of the fact that the Board of Trustees has felt it unwise for units of the Society to seek federal funds although the Board did authorize the preparation of the application which resulted in the creation and funding of the Susquehanna Valley Regional Medical Program.

"The Reference Committee appreciates the position of the Board with respect to this matter. However, it believes the day has come when the House of Delegates should express the need for greater latitude."

MR. PERRY
TO RETIRE

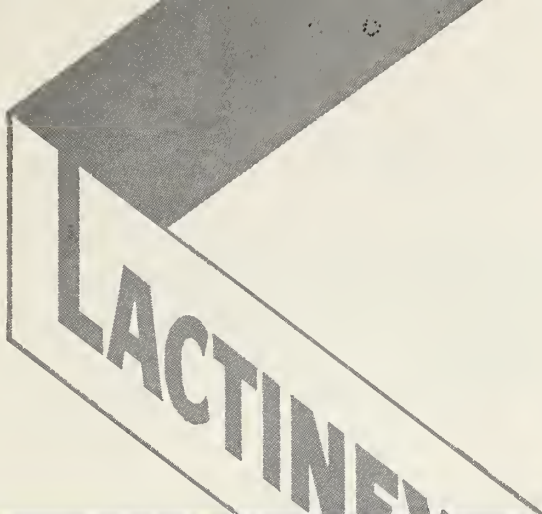
The Board of Trustees, in a supplemental report to the House, announced that Mr. Lester H. Perry, the Executive Director of the State Society, would retire at the conclusion of the 1969 session of the House and that Mr. John F. Rineman, currently the Assistant Executive Director, had been selected to succeed Mr. Perry. The House "noted with regret" Mr. Perry's intending retirement, acknowledged his many achievements and commended his long term of honorable service. The House also endorsed the Board action in selecting Mr. Rineman as Mr. Perry's successor.

GHETTO CARE ENDORSED

The House took related actions directing the State Society to formulate plans for assuring the availability of quality medical care in all areas of the state, including ghetto areas and other economically deficient sectors. A volunteer physician effort, such as now takes place overseas with programs such as Medico and the ship HOPE, was suggested for such areas in our own state. The "resolve" of an approved resolution on the subject reads as follows: "That the Pennsylvania Medical Society will emphasize the development of programs designed to improve the physical well-being of the disadvantaged in Pennsylvania; will identify and eliminate internal barriers in policy and/or procedure which contribute to the problem of providing adequate health care for all; and will commit resources toward developing efforts to fight poverty and inequality; including joining with other organizations to multiply the effectiveness of the fight."

AMA DELEGATE LIMIT REJECTED

Upon the recommendation of the Reference Committee on Constitution and Bylaws, the House postponed indefinitely action on limiting the number of terms a delegate to the AMA may serve. Such a limit had been suggested to last year's House by Dr. Harris and a similar recommendation was made this year by Dr. Farrar who had suggested a maximum of six, two-year terms. The approved reference committee report stated: "It was pointed out at the Reference Committee hearing that the Pennsylvania Delegation to the AMA can operate effectively only if the delegation is largely composed of experienced persons. It was also suggested that some of the Pennsylvania physicians who have records of distinguished leadership at the AMA level could never have achieved high office in the AMA if they had been removed from the delegation at a mid-point in their service." The Reference Committee noted that the House currently has the privilege of replacing half of the delegation every year if it so chooses. It also was pointed out that three members of the delegation are retiring voluntarily this year and it suggested that such voluntary retirement should continue. The House referred the Reference Committee comment to the Committee to Nominate Delegates and Alternates to the AMA for the guidance of the committee.



LACTINEX[®]

TABLETS & GRANULES

■ to help restore and stabilize
the intestinal flora

■ for fever blisters and canker
sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,^{1, 2, 3, 4} LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.^{5, 6, 7, 8}

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

- (1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., 58:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, 25:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., 20:591-593, November 1965.

**HYNSON, WESTCOTT
& DUNNING, INC.**



BALTIMORE, MARYLAND 21201

(LXD4)



PENNSYLVANIA MEDICINE®

© 1968 Pennsylvania Medical Society

The Pennsylvania Medical Journal
Official Publication of the Pennsylvania Medical Society

OCTOBER, 1968

VOLUME 71, NUMBER 10

ORIGINAL PAPERS

Occipital Neuralgia	85
Reducing Absenteeism Resulting from Upper Respiratory Complaints	89

FEATURES

Appalachia Helps Build Medical Facilities	91
Health Manpower	94
Rubella in Pennsylvania	96

NEWSFRONTS

"Quo Vadis" Continuing Education?	7
Dr. Potter Assigned New Post	8
New Blue Shield National I.D.	10
Close-up/M.D.s	26
Capitol Report	44

EDITORIALS

The Federal Government Is Talking to You, Doctor.	49
--	----

SCIENTIFIC REPORTS

Cardiovascular Briefs	83
Cancer Forum	107

GENERAL

Scientific Seminars Program	67
Continuing Education	104
Meetings	109
Obituaries	110
Classified	112
Write Now	114
In My Opinion	118

PUBLISHED MONTHLY BY THE
PENNSYLVANIA MEDICAL SOCIETY
TAYLOR BYPASS AND ERFORD ROAD,
LEMOYNE, PENNSYLVANIA 17043

Subscription \$5.00 Single Copy 50¢

PUBLICATION COMMITTEE

Joseph A. Walsh, M.D., Blakely-Olyphant
Chairman
D. George Bloom, M.D., Johnstown
H. Thompson Dale, M.D., State College
William J. Kelly, M.D., Pittsburgh
Robert S. Sanford, M.D., Mansfield

STAFF

Carl B. Lechner, M.D., 4111 Beech Avenue,
Erie 16508—Medical Editor
David A. Smith, M.D., Polyclinic Hospital,
Harrisburg 17105—Associate Medical
Editor
Thomas J. McCaghren, Taylor Bypass and
Erford Road, Lemoyne 17043—Managing
Editor
Claudia Helsel, Taylor Bypass and Erford
Road, Lemoyne 17043—Editorial
Assistant

CONTRIBUTING EDITORS

Harry E. Bacon, M.D., Philadelphia
William C. Beck, M.D., Sayre
Walter I. Buchert, M.D., Danville
Lewis T. Buckman, M.D., Wilkes-Barre
A. Reynolds Crane, M.D., Philadelphia
Garfield G. Duncan, M.D., Philadelphia
Mario N. Fabi, M.D., Scranton
George H. Fetterman, M.D., Pittsburgh
Wendell B. Gordon, M.D., Pittsburgh
Samuel B. Hadden, M.D., Philadelphia
Jack D. Myers, M.D., Pittsburgh
William Likoff, M.D., Philadelphia
Eugene P. Pendergrass, M.D., Philadelphia
Mary DeWitt Pettit, M.D., Philadelphia
Sydney E. Sinclair, M.D., Camp Hill
David A. Smith, M.D., Harrisburg
James R. Watson, M.D., Pittsburgh

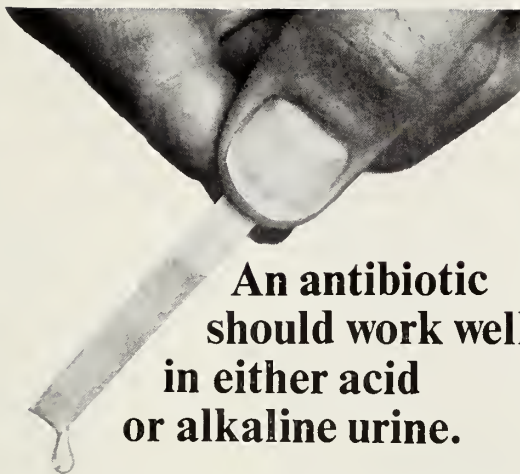
• **GENERAL.** Established 1897. Pennsylvania Medicine may not be held responsible for opinions expressed in any of its contents.

• **EDITORIAL.** Address all original papers, features, and editorial correspondence to the Managing Editor.

• **ADVERTISING.** Pennsylvania Medicine's advertising policy conforms with principles governing advertising in American Medical Association scientific publications. National advertising representatives: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago, Illinois 60610. Advertising rates on request to Pennsylvania Medicine office, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043, or the SMJAB. For classified rates, see classified section.

• **MAILING.** Second-class postage paid at Lemoyne, Pennsylvania.

• **CHANGE OF ADDRESS.** Give name, old address, new address (include ZIP number), state if change is permanent or temporary. Send notice to Pennsylvania Medicine, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043. Allow six weeks for change of address.



**An antibiotic
should work well
in either acid
or alkaline urine.**

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system — anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin — maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney — rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated — 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-B

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York



Geigy



onedownmanship

Regroton[®]

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Regroton produces a smooth, long-acting effect that usually reduces both systolic and diastolic pressures. At the same time it often acts to allay anxiety and nervous tension associated with hypertension.

Although Regroton is generally well tolerated, adverse reactions may occur. This drug is contraindicated in mental depression, demonstrated hypersensitivity, and most cases of severe renal or hepatic diseases. For a complete list of side effects, please see the Prescribing Information summarized on the following page.

Regroton[®]

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur



during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.

Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-C

For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation 
Ardsley, New York 10502

RE 6225



newsfronts

Television in the Forum

"Quo Vadis" Continuing Education?



Television—why and where in continuing medical education—is discussed in depth by a select group of physicians, educators and television representatives under the chairmanship of Richard B. Magee, M.D., Blair County, at the headquarters of the Pennsylvania Medical Society.

The output of the printed word is fast outstripping our ability to select, read, and digest; and among this mass of data and material is information critically important to the physician.

Can television distill the printed words and provide effective communications for the physician?

What are the possibilities for the use of television in medical practice?

What is the position of the Department of Public Instruction regarding use of educational television beyond the public school system?

What should be the content of medical television programs?

Does commercial and cable television have a place in communicating to physicians?

Can there be a master plan for communicating to physicians by the media of television?

These questions formed the basis for the agenda of a meeting to study the exploration of a statewide medical education television network at the Pennsylvania Medical Society headquarters, July 24th, under the direction of Richard B. Magee, M.D., Chairman-elect of the Council on Scientific Advancement.

Among the notable speakers at the all-day session were Marlowe Froke, director of broadcasting, WPSX-TV, University Park; Niles D. Coon, Ed.D., director of the bureau of instructional services, department of public instruction; Campbell Moses, M.D., director of postgraduate medical education program, University of Pittsburgh School of Medicine; Frank Cummins, WJAC-TV, Johnstown, and Kenneth Brubaker, general manager, Altoona Cable TV.

The Council on Scientific Advancement, charged with promoting the program of continuing medical education for the Pennsylvania Medical Society, took the initiative in calling the meeting of thirty-five people, representing various disciplines, who are interested in television as it relates to continuing medical education.

The need for a new medium in gaining the interest and attention of physicians in continuing medical education is apparent. A number of specific areas of application of television in medical education were voiced by participants in the conference:

- "Guest specialist"—attend regular-

ly scheduled staff conferences via two-way television.

- Transmission of whole conferences from one hospital to another.

- Instant consultation with specialists at medical centers with specific regard to x-ray, electrocardiogram and microscopic tissue interpretation.

- Instant clinical consultation by showing the patient and chart to a consultant located at some distant point.

- "Loop circulation" concept of continuing medical programs that would be interrupted by special programs from time to time. In other words, house staff and attending staff could switch on medical television at any time, say from 8:00 a.m. to 5:00 p.m., and secure some medical educational material—specific material would be programmed throughout the day on a regular schedule. TV monitors could be strategically placed throughout the hospital, but specifically in physicians' lounge areas.

A number of techniques were suggested as to actual application of television to continuing medical education, and the conferees agreed that the most ideal situation would involve a two-way voice and video system. While "non-public" broadcasts are deemed desirable, many of the participants felt that it was not essential to conceal medical television from the public.

It was pointed out during the day-long session that universal two-way systems would bring to continuing medical education a high degree of relevance and immediacy. This would not only improve the educational experience of the physician, but at the same time would directly aid the pa-

(Continued on page 16.)

Richard J. Potter, M.D. Assigned State Post

Governor Raymond P. Shafer has named Richard J. Potter, M.D., a former official of the State Department of Health, as its Deputy Secretary to replace Dr. Ralph E. Dwork who resigned to join the staff of the New York State Department of Health.

Formerly Director of the Marquette County Health Department, Marquette, Michigan, where he had served since 1966, Dr. Potter, 44, assumed his new duties with the Department on September 3. He will be paid \$26,367 in his new post.

"Pennsylvania is fortunate to have Dr. Potter return to the Department of Health," Governor Shafer said. "His past experience in the Harrisburg central office and in the regional health organization will prove invaluable."

A native of East Mauch Chunk, Dr. Potter attended Muhlenberg College, Allentown, and received his M.D. degree from Jefferson Medical College, Philadelphia, in 1948. In

1959 he was awarded the Master of Public Health degree from the University of Pittsburgh Graduate School of Public Health. His internship was served in St. Luke's Hospital, Bethlehem.

His extensive previous service in the



Richard J. Potter, M.D.

Pennsylvania Department of Health includes three years as Regional Medical Director in Kingston (1962 to 1965) and three years in Harrisburg as chief of the diagnostic and clinic services section of the Division of Tuberculosis Control (1959 to 1962).

He was a staff member of the Samuel G. Dixon State Hospital from 1949 to 1952 and 1955 to 1958, and also served as Deputy State and County Health Officer in Baltimore County, Maryland, from 1965 to 1966 and was in general practice in Corry, Pennsylvania, from 1953 to 1955.

Dr. Potter's professional memberships include the Michigan State Medical Society, Marquette-Alger County Medical Society, Michigan Health Officers Association, and American Public Health Association.

He is an associate fellow, American College of Chest Physicians, and fellow, American College of Preventive Medicine. He is certified by the American Board of Preventive Medicine in Public Health.

Samuel G. Dixon Sanitarium To Become Geriatric Center

The venerable Samuel G. Dixon Hospital in South Mountain, Franklin County, known to scores of thousands of TB patients as Mt. Alto, enters a new phase of its sixty-year existence as it becomes a Commonwealth geriatric center.

Complex logistical arrangements involving the transfer of 945 tuberculosis patients to Commonwealth hospitals in Pittsburgh and Philadelphia and conversion of the Dixon facilities for care of geriatric patients have now been completed.

Dixon's phase-out operation as a tuberculosis hospital was carried out under the immediate direction of Harold E. Coder, M.D., Director, Division of Chronic Respiratory Diseases, Department of Health, and Alfred C. Kraft, M.D., as Director, Geriatric Center Program, and now Acting Commissioner for General and Special Hospitals, Department of Public Welfare.

Plans to phase out the tuberculosis

program at Dixon as a Health Department facility and conversion to a Welfare Department geriatric center were made after careful study and analysis of total requirements for tuberculosis hospital beds in Pennsylvania. Secretary of Health Thomas W. Georges, Jr., M.D., pointed out that the Dixon facility had a TB patient census of 812 in October, 1957, a census of 298 patients in October, 1967, and declined to 196 as of January 28, 1968.

Outpatient Diagnostic

CBC, Geisinger Test Hospital Stays

Establishment of a diagnostic testing program designed to shorten the hospital stay of patients was jointly announced by Capital Blue Cross and Geisinger Medical Center, Danville.

The program, known as Pre-Admission Testing (PAT), will enable subscribers scheduled for hospital admission to receive, as a Blue Cross benefit, routine and specific diagnostic services prior to actual admission as an inpatient.

Under the PAT program, Blue Cross subscribers who are scheduled to be admitted to a hospital participating in the program may receive on an outpatient basis those services usually provided subscribers as "in-hospital" benefits.

Services covered under this program include laboratory, x-ray, electrocardiogram and electroencephalogram services, metabolism testing, cystoscopy examinations and proctology examinations. Normally these services are covered as an inpatient benefit or, in some cases, when subscribers are enrolled for certain outpatient diagnostic services as part of their basic Blue Cross contract.

Studies have shown that the first few days of a hospital stay are frequently used for conducting tests before treatment actually begins.

The major objectives of the program are twofold: first, to assist hospital scheduling of services and bed assignments, and secondly, it is designed to reduce the length of stay of patients in a hospital by allowing routine and specific services to be rendered, whenever possible, on a less expensive outpatient basis.



Petition signed by 45,000 voters seeking a referendum on the establishment of a Delaware County Department of Health in November is presented to Emil D'Alesio (right) assistant chief clerk of the county election department in Media by William Y. Rial, M.D. (left), president of Citizens for Better Public Health, and Arthur Silvers, M.D., president of the county medical society.

Dr. Rial Heads Citizens' Committee

Delaware County Seeks Local Health Department

Growing health problems in Delaware County must be combated with a county health unit "before they get so bad they are taken completely out of our hands," a Delaware County Health and Welfare Council, Inc., official has stated.

"Pollution, poor sanitation practices, lack of health education . . . These shortcomings are growing faster than even our expanding population," said Council Executive Director Peter Brigham.

He said an effective countywide method of dealing with these shortcomings must be found or the responsibility to do so may be sacrificed to a form of regionalism or higher government program.

Delaware County voters apparently will have the chance to vote for or against the establishment of a Delaware County health department in the November 5 election.

William Y. Rial, M.D., Swarthmore,

president of the Citizens for Better Public Health (CBPH) and Speaker, PMS House of Delegates, said his group has obtained enough petition signatures to force a referendum on the question in the general election.

CBPH claims a centralized health agency is needed to cope with the increasingly complex health problems of a county with a 600,000 population.

At present, each of the county's forty-nine municipalities either has its own health department—there are thirty-nine separate health boards in the county set-up—or relies on the state for health services.

"State and federal governments would probably not be as sensitive to our special needs here in Delaware County as a county health unit," said Brigham.

Opposing the county health unit idea are most of the persons involved in the present local boards of health system.

They argue the county group would be too costly, inefficient and take away the health responsibility from the "grass roots."

"The great majority of the people we spoke to were completely unaware they had a board of health in their own municipalities," replied Brigham to such charges. "The local boards do little more than provide limited environmental sanitation services. A county unit would produce a more effective communicable disease control program, a professional and standardized environmental sanitation program, more extensive health education and better coordination with state and federal agencies with such complex problems as air pollution."

Delaware County would be eligible for state funds for its proposed health department, Dr. Rial said.

Dr. Rial responded to remarks made by Republican County Commissioners Frank A. Snear, Jr., and Harry A. McNichol who said the Pennsylvania Department of Health would have to declare the county "entitled" to a health department before the plan for one could be placed on the November 5 ballot.

They also said the state would have to approve a health program the county is preparing before the issue could go on the ballot, and noted the commissioners know when this data would be submitted to the state health department.

Dr. Rial said the state would contribute half of the estimated \$900,000 to operate a county health department each year. He said data on the program could be prepared quickly and stressed he was confident the date would be approved promptly by the state.

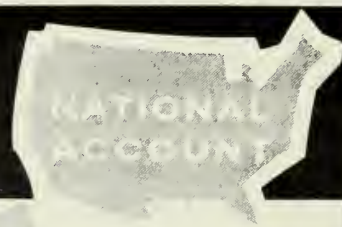
Ninety percent of a random sampling of Delaware County residents favor establishment of a countywide health board, according to a survey conducted by a political group supporting Democratic County Commissioner Edward T. McErlean.

McErlean said he thinks the number of persons who responded to the survey—102 of 1,046 contacted last January—represents a high percentage of returns as far as a mail survey is concerned.

Although the surveys show the majority of participants favoring a consolidation of local health boards, McErlean is keeping secret, for the time being, a second report on the feasibility of setting up a county health board.

New Blue Shield National I.D.

BLUE SHIELD®
IDENTIFICATION CARD



SUBSCRIBER				CODE			
GROUP	PLAN	CERTIFICATE	MO. DAY YEAR EFFECTIVE				

Physicians and their office assistants will be seeing more patients carrying Blue Shield's new identification card designed for subscribers in certain "national account" groups.

This new national account ID card is being given to employees of large organizations whose offices are located in different areas of the country, involving a number of Blue Shield plans.

The card for national accounts looks somewhat different from the type issued by a local Blue Shield plan. It carries the words "Blue Shield Identification Card" across the top and the words "National Account" printed over the silhouette of a map of the United States.

When the medical office provides professional services to a patient carrying one of these Blue Shield national account cards, the regular claim form should be completed and filed with the local Blue Shield plan.

This is particularly important for determining usual and customary fees for subscribers having this type of benefit program. Only the host Blue Shield plan can determine a proper al-

lowance for physician's services within its area.

Use of the new card will help to expedite the processing of claims by facilitating the determination of a subscriber's eligibility for benefits. Medical and hospital benefits for employees are uniform within centrally-certified groups, regardless of where the individual employee may be located.

Blue Shield National Accounts in Pennsylvania are: AFTRA Welfare Fund; American Hospital Supply Company; American Metal Climax, Inc.; American Newspaper Publishers Association; American Telephone and Telegraph; Avis Rent-A-Car; Breneman, Inc.; Ciba Corp.; Dow Jones & Co., Inc.; Essex Chemical Corp.; Home Insurance Company; Honeywell, Inc.; IBM, Corp.; Joint Board of Fur and Leather Machine Workers; S. S. Kresge, Company; The New Jersey Zinc Co.; Ohio Casualty Insurance Company; Petrie Stores Corp.; Q. T. Shoe Manufacturing Company; Royal Globe Insurance; Snacks, Inc.; Stouffer's Food Corp.; United Press International; and Uniroyal, Inc.

AMA Speaks On Use of Plasma

"The use of whole, pooled human plasma," according to a statement released by the American Medical Association to officials of state and county medical societies, "will be discouraged and even discontinued unless a clear-cut case can be made for its unique requirements" is a recent recommendation of the Committee on Plasma and Plasma Substitutes, Division of Medical Sciences, National Research Council.

The Committee on Blood, American Medical Association, is reporting this action to constituent and component medical societies so that physicians may be informed promptly.

In the opinion of the Committee on Blood, the latest and best evidence supported by opinion of experts of the National Research Council, is that pooled plasma from large numbers of donors, prepared by irradiation and storage at 30-32° C. for six months, appears to carry a higher risk than was indicated by previous publications. The relative risk of plasma prepared from smaller donor pools and stored for longer periods, or at higher temperatures, was not investigated in this study.

The Committee on Blood notes that alternatives to the use of pooled plasma are available in single donor plasma and serum albumin. In acute requirements the risk from any pooled plasma must be evaluated against the compelling needs for its use.

Air Control Regions Located in Two Pennsylvania Cities

Secretary of Health, Education, and Welfare Wilbur J. Cohen announced that Philadelphia and Pittsburgh are among thirty-two air quality control regions to be designated during the next twelve months.

Under the Air Quality Act, which became law in November 1967, designation of regions is a fundamental step leading toward action by state governments, who will be responsible for adopting and enforcing standards to control air pollution on a regional basis.

Dr. Harris Addresses Democratic Platform Committee

In an unprecedented and forceful address at the regional hearing of the Democratic Congressional Platform Committee in Harrisburg, August 15, John H. Harris, M.D., then President of the Pennsylvania Medical Society appealed for governmental support of the medical profession in its continuing effort to provide quality health care for all our people.

While he neither spanked nor appeased the distinguished members of this policy formulating group, Dr. Harris was candid and lucid in his interpretation of the medical profession's stand on problems of drug prescription, health care costs, health care payment, employment for the aged, health manpower and mental health.

In citing the startling new approach to the prolongation of life—the heart transplant—the Pennsylvania radiologist described the possibility of this development as just one indication of the vitality of medical research and practice that can only exist in a free society where free men can work and exchange their thoughts and ideas.

In representing the members of the Pennsylvania Medical Society, and all members of the healing art in general, Dr. Harris first recommended to the Democratic Party that in its platform it continue to urge the freedom and opportunity to those engaged in medicine and the allied sciences this unfettered atmosphere to pursue the common goal of a better and more healthful life for everyone.

Dr. Harris called the committee's attention to the issue of prescribing drugs in the treatment of human illness and strongly recommended that the Democratic Party oppose the proposition that would force recipients of government medical care programs to a second-class status by restricting the amount and kind of drugs for which the government would pay.

Dr. Harris pointed out that much attention has been focused on the cost of drugs while at the same time relating the cost to the appropriate selection of drugs. "The individual doctor cannot divorce himself from the patient's problem of financing his health care costs . . . More important, however, and of principal concern to Medicine, is the freedom of the physician to choose the appropriate drug," stated Dr. Harris. "This

judgment must never be restricted, overruled by law, or regulated by a decision of any third party."

Relating to the high cost of health care as a problem of great national interest, Dr. Harris advised the Democratic Platform Committee that the AMA is expected to recommend the establishment of a Cabinet-level department of health, headed by a physician, to review new and old tax-supported programs in the health field so that while the best health care is obtained, wasteful and unnecessary programs can be eliminated.

The problem, according to Dr. Harris, "will not be abated as long as the

ing demand for more health and medical service.

"To meet this demand," says Dr. Harris, "we have recommended a prompt and substantial increase in the capacity of existing medical schools and the establishment of new schools . . . we will continue to recommend marked increases in the support for medical education through the provision of funds by local, state and federal governments, foundations, industry, and private individuals for accommodations and operations.

"Also critical is the need for an increase in paramedical personnel so that the physician's time can be put to more effective use."

Switching to the subject of mental health, Dr. Harris said that in the progress report of the Johnson Administration's health programs, a chart shows the decline in state mental hospital population.

"We have seen great strides in Pennsylvania in the methods that are being used to treat mental illness," said Dr. Harris.

The one big problem remaining in mental health programs, according to the PMS official, are the attitudes of the public. "We believe that the stigma attached to the mental patient, to the alcoholic, the drug addict, can be erased and quality health care extended by encouraging the extension of health insurance coverage to include these areas," continued Dr. Harris. "It is in this field that the partnership between the federal, state and local governments, the medical profession, the voluntary associations must continue if we are to solve it."

In expressing Medicine's desire to make quality health care more readily attainable to all people, Dr. Harris recommended to the Democratic Platform Committee that the Congress and the next administration embark on a program of tax credits for health insurance premiums under which all families and individuals would be encouraged to provide themselves with health care insurance. For those who need financial assistance, a graduated basis of tax credit would be given.

". . . We are firmly convinced," said Dr. Harris, "that adequate health care insurance coverage is the best mechanism for the financing of quality health care costs."

Network TV To Repeat Sex Education Film

The American Broadcasting Company's award-winning television documentary "How Life Begins" will be repeated on the network, October 14. The hour-long color presentation on sex education has earned a re-run because of the many requests from parents who missed the interesting study on the origin of life first presented last season. It is the kind of vehicle that a physician would want to recommend for parents and children.

demand for health services continues to outrun the supply of providers; and as long as scientific advances in medicine are made and general inflationary cost trends continue to rise. Perhaps the most influencing factor is the higher quality of care that is being demanded."

He indicated that the public seems to accept increased costs due to scientific advances and higher quality care, but objects to rising costs because of manpower shortages and general inflationary trends.

In keeping with this, Dr. Harris pointed out that one of the problems that occupies a great deal of our attention at the moment is the ris-

Population Concerns Health Dept.; Dr. Georges Outlines Studies

Pennsylvania's changing population—estimated to be 12 and a quarter million residents by 1970—is one of the major concerns of the State Health Department's comprehensive planning approach aimed at providing adequate public health care for some 8.3 per cent more people since the 1960 census.

An analytical Pennsylvania population profile study completed recently by the Health Department's Bureau of Planning, Evaluation and Research indicates that some areas of the Commonwealth are growing rapidly while others are remaining static. Reasons for these gains or losses are of major importance to health planners:

—Population growth rate in the southeastern section of the State including Philadelphia is nearly twice the rate for the State as a whole.

—Population growth in the southwestern section of the State including Pittsburgh is relatively slow.

—Population is relatively stable in the northeastern section of the State including Scranton and Wilkes-Barre.

—The south central area including the cities of York, Lancaster and Harrisburg is the fastest growing region in the Commonwealth.

Noting that complete understanding of population trends, as well as other factors such as income, age and industry, is essential for efficient health planning, Health Secretary Thomas W. Georges, Jr., M.D., said that studies of this nature will enable Pennsylvanians to "benefit from health services and programs tailored to people instead of to diseases, as has generally been the case in the past."

Some knowledge of the population—its size growth and characteristics—is of interest to nearly everyone, Dr. Georges pointed out. "But it is of particular importance," he continued, "to persons engaged in the provision and delivery of medical care and other health services to the people."

He explained that, in varying degrees of refinement, population data

show health planners the nature of the community with which they are concerned; they indicate things that need to be done; and they direct where, when and how efforts should be made.

"Finally," he said, "complete population information provides a means for evaluating progress once programs have been put into operation."

The recently completed study analyzes the size, distribution and density of Pennsylvania's population from 1940 to 1970 for the State as a whole and on a regional and county-by-county basis.

The regional breakdown is in line with the six "human services" regions scheduled to be used by the Health Department and other State agencies in the future for better, more economical coordination of their programs.

A second State and regional study by Health Department researchers with major implications for health and other program planners has been under way. Concerned with the Commonwealth's population in terms of age, sex, race and nativity over the past three decades, the study was scheduled to be completed this summer.

Two additional studies are also being planned, one to examine the social and economic characteristics of the population and the other to be involved with vital statistics—births, deaths and the incidence of disease.

Preliminary information for the studies is being drawn from a variety of sources that include: the State Planning Board, publications of the U.S. Bureau of the Census, Pennsylvania Statistical Abstracts, and vital statistics summaries published by the Health Department's Division of Data Processing.

Coordinating the preparation of the analytical studies are Dr. Charles O. Crawford, director of the Health Department's Division of Behavioral Science, and Public Health Behavioral Research Associate George W. Schelzel, under the supervision of Dr. A. L. Chapman, director of the Bureau of Planning Evaluation and Research.



William C. Long, Jr., of Lock Haven, secretary of the Clinton County Medical Society, listens to some of the radio programming produced by the State Society during a day-long visit to PMS headquarters. The orientation visits for county society secretaries are arranged by the Council on Public Service.

Philadelphia Slated For Narcotic Center

Philadelphia is among six sites chosen by the National Institute of Mental Health for community-based treatment programs for narcotic addicts.

The six centers, also including New York, Albuquerque, Chicago, St. Louis, and New Haven, will serve areas containing more than 3.4 million persons and an estimated 16,000 known heroin addicts and users.

Providing comprehensive care for addicts in their home communities is a new concept in the treatment of addiction and is designed to reduce the number of ex-addicts who return to the drug habit. A high relapse rate has been a major problem in the treatment of heroin addicts, according to medical experts.

The establishment of these centers is a first move in removing treatment services from the NIMH clinical research centers at Lexington, Ky., and Ft. Worth, Texas.

Pa. Firms Engaged In Heart Device Development Program

The Artificial Heart Program of the National Heart Institute, National Institutes of Health, has awarded eight new research contracts and extensions to Pennsylvania organizations among ninety-nine throughout the nation for studies basic to the development of devices and techniques for providing circulatory assistance to damaged or failing hearts.

A long-term goal of this program is a completely implantable, permanent heart replacement. Present efforts, however, are centered on the development of a family of devices to assist, rather than replace, the hearts of patients with acute or chronic heart failure resulting from heart attacks or other conditions.

Three types of devices are needed: Emergency-assist devices—to sustain life in victims of heart attacks or other circulatory crises until the patient can be delivered in salvageable condition to the hospital; Temporary-assist devices—applicable to patients with acute heart failure, but good prospects of complete recovery provided that their hearts can be given a respite to mend damage sustained during a heart attack or to recover from the stress of surgery; and Permanent-assist devices—designed to restore such patients to useful, productive lives.

New contracts in the Artificial Heart Program have been awarded to: The Holter Company, Bridgeport (\$112,925) for the analysis and measurement of the effects of materials on blood; University of Pennsylvania, Philadelphia (\$57,478) for the development of a variety of assisted circulation devices and techniques; University City Science Center, Philadelphia (\$60,000) for the development of facilities to rigorously test and evaluate circulatory assist devices and techniques, and Pennsylvania Research Associates, Inc., Philadelphia (\$47,682) for the development of a biological fuel cell compact and light enough for implantation, yet powerful enough to deliver up to 20 watts of power.

Contract continuations were granted to Carnegie-Mellon University, Pittsburgh (\$105,000) and Polysciences,

Inc., Rydal (\$55,365) for the development of devices for temporary or long-term support; Westinghouse Electric Corporation, Pittsburgh (\$106,006) for the further development of a variety of assisted circulation devices and techniques, and the General Electric Company, Philadelphia (\$73,935) for the search of basic information on bloodflow that may prove valuable in designing circula-

tory assist devices with gentler blood-handling characteristics.

Emergency-assist devices and temporary-assist devices are already well along in their development. Although none is ideal, several of both types have shown considerable promise in limited clinical trials.

The problems posed by permanent-assist devices are more formidable and are largely unsolved at present.

AMA Posture on Public Comment

Because of the great increase in attention being given to medicine and health care in the press and broadcast media, and because the medical profession is now the focus of one of America's greatest interests, the Board of Trustees of the American Medical Association recommended, and the AMA House of Delegates approved, a new posture on public comment.

The profession may now expect to be in the spotlight constantly, ending the professional reticence and privacy in which medicine functioned most of the time in the past. Even though this interest is a tribute to the importance of Medicine and the public's desire for its benefits, it brings with it the problems facing any person or organization with a key public position: much of the coverage is critical or displays a lack of understanding.

The conclusions that have resulted from an intensive and thoughtful consultation among the AMA board of trustees, staff, and public relations counsel on this increasingly important situation are:

Report of the Board of Trustees

1. When statements about Medicine are misguided or unfair, corrective statements will be issued promptly when the facts are available and an orderly response is possible.

2. We must recognize that the prominence and complexity of Medicine in the United States today results in many limitations. Medicine is a constant subject of news and comment, much of which cannot be subject to a later response. Often our replies cannot be carried by the broadcast medium or publication, or at best will be much less prominent than the original coverage. Quite often a responsible statement cannot be is-

sued until the facts have been obtained, and these may be scattered about the country or involve a local situation or require a great deal of time.

3. The frequency and complexity of these matters have increasingly diverted the officers and staff of the AMA to reacting to what others do and say. This decreases the ability to work on constructive, ongoing activities that are vital to our future.

4. Staff is developing in written form the best possible anticipatory statements regarding all foreseeable circumstances. By having such matters thought out and documented when a need arises, we will be able to reduce the instances of surprise, decrease the time required for response, and assure consistency in AMA statements on these matters.

5. We will concentrate on building a positive posture by getting understanding for Medicine's functions and its positions on various considerations; and by educating the press, broadcasters and opinion leaders. This will help forestall much misguided criticism and build a favorable climate that will inoculate against susceptibility to unfair criticism.

6. All state and county medical societies are urged to follow these same procedures.

There will be many instances in which the AMA will respond to public comment and there will be many in which they have acted but the effectiveness will be in correcting the source and may not be immediately visible. There will also be instances when judgment indicates a response should not be made. In each case, the best judgment and skills available will have been applied to the complexities of the situation.



*“Upper respiratory infection! I thought everything
was a ‘virus’ these days?”*

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® in two different tablet formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

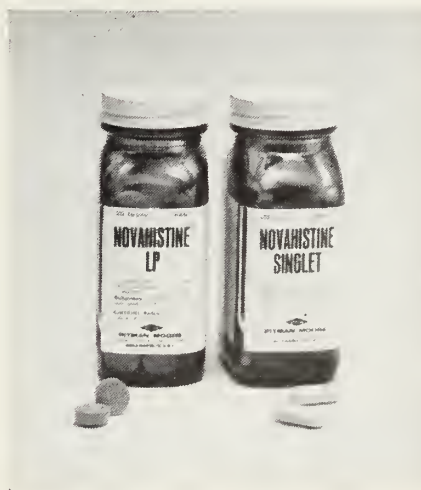
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



Dow PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

"Quo Vadis" Continuing Education?

(Continued from page 7.)

tient or patients involved and improve medical care.

The factors of relevance and immediacy tend to make for greater retention of a second system, which is already in operation around the Pittsburgh area under the direction of Campbell Moses, M.D., involving a one-way television with a back-up telephone system in the opposite direction.

The third system provides good educational experience and has become popular in some areas involving the use of "slave television," utilizing previously taped programs, shown on schedules designed by local hospitals. While interesting, it provides little more stimulation than the many excellent movie films available on medical subjects. This system is currently in use in many places throughout the Commonwealth.

In principle, the conferees agreed that the Council on Scientific Advancement should provide forceful leadership in developing television as the prime modality for continuing medical education; that a special task force should be set up by the Council to explore engineering feasibilities and programs to satisfy local education needs throughout Pennsylvania; and that the primary objective be to establish a universal two-way television, since it will be most advantageous to any modality of use and will provide relevance and immediacy in that factual material learned in this general frame of reference is far better retained than that learned through other modalities.

In addition to the featured speakers mentioned previously, the meeting was also attended by: Jack Borland, manager, general promotion department, Smith, Kline and French Labs; Clement R. Brown, M.D., director, medical education, Chestnut Hill Hospital, Philadelphia; Robert R. Carpenter, M.D., director, Western Pennsylvania Regional Medical Program; David W. Clare, M.D., Pittsburgh; Robert L. Evans, M.D., director, department of medical education, York Hospital; George E. Farrar, M.D., then President-elect, Pennsylvania Medical Society; Sidney A. Goldblatt, M.D., Johnstown; John Halloran, executive vice president, American Cancer Society, Pennsylvania Division; George

T. Harrell, M.D., dean, Pennsylvania State University College of Medicine; John H. Harris, Sr., then President, Pennsylvania Medical Society; John Hoffman, staff assistant, Susquehanna Valley Regional Medical Program; John F. Huber, M.D., Temple University School of Medicine; John H. Killough, M.D., associate dean, Jefferson Medical College; Henry L. Lewis, marketing department, Bell Telephone Company; Charles T. Mears, executive director, Pennsylvania Heart Association; Philip Mechanick, M.D., Hospital of the University of Pennsylvania; Richard H. Michaels, M.D., clinical assistant professor of pediatrics, University of Pittsburgh School of Medicine; Jacob Pyenson, electronics engineer, closed circuit TV, Hahnemann Medical College; Kenneth Richardson, M.D., clinical assistant professor of ophthalmology, University of Pittsburgh School of Medicine; Jack Rothstein, medical promotion manager, Wyeth Laboratories, Philadelphia; David Wagner, M.D., assistant professor of surgery, institutional representative, regional medical program, The Woman's Medical College of Pennsylvania; Everett C. Waltman, chairman, task force on communications, Susquehanna Valley Regional Medical Program; Roger Wolfe, technician, University of Pittsburgh School of Medicine; John F. Worman, executive directory, Hospital Association of Pennsylvania; Leroy Erickson, executive assistant for the PMS Council on Scientific Advancement; Robert Lamb, PMS staff assistant; Velma McMaster, PMS staff assistant; Sam Price, PMS staff assistant and Albert Derr, television consultant, Hahnemann Medical College.

EPPI Awarded Grant For Suicide Study

Dr. Joseph Adlestein, Deputy Secretary for Mental Health in the Department of Public Welfare, announced that the Eastern Pennsylvania Psychiatric Institute, Philadelphia, has been awarded a three year federal grant from the Center for Studies in Suicide Prevention of the National Institute of Mental Health (NIMH) to study problems of bereaved families.

WETHERHOLD
AND *Thomas Shoes*
METZGER

**WE'RE
SPECIALISTS
IN FITTING
"SPECIAL" FEET**



THE
STRIDE RITE
SHOE

**Orthopedic Fitting and
Orthopedic shoes always in stock**

—ALLENTOWN—

• UP-TOWN STORES
953 Hamilton St.
951 Hamilton St.

• CENTRAL STORE
719 Hamilton St.

PMS Radio Produces Drug Documentaries

The third in a series of radio documentaries produced and distributed by the PMS Council on Public Service is being offered to all radio stations in the state.

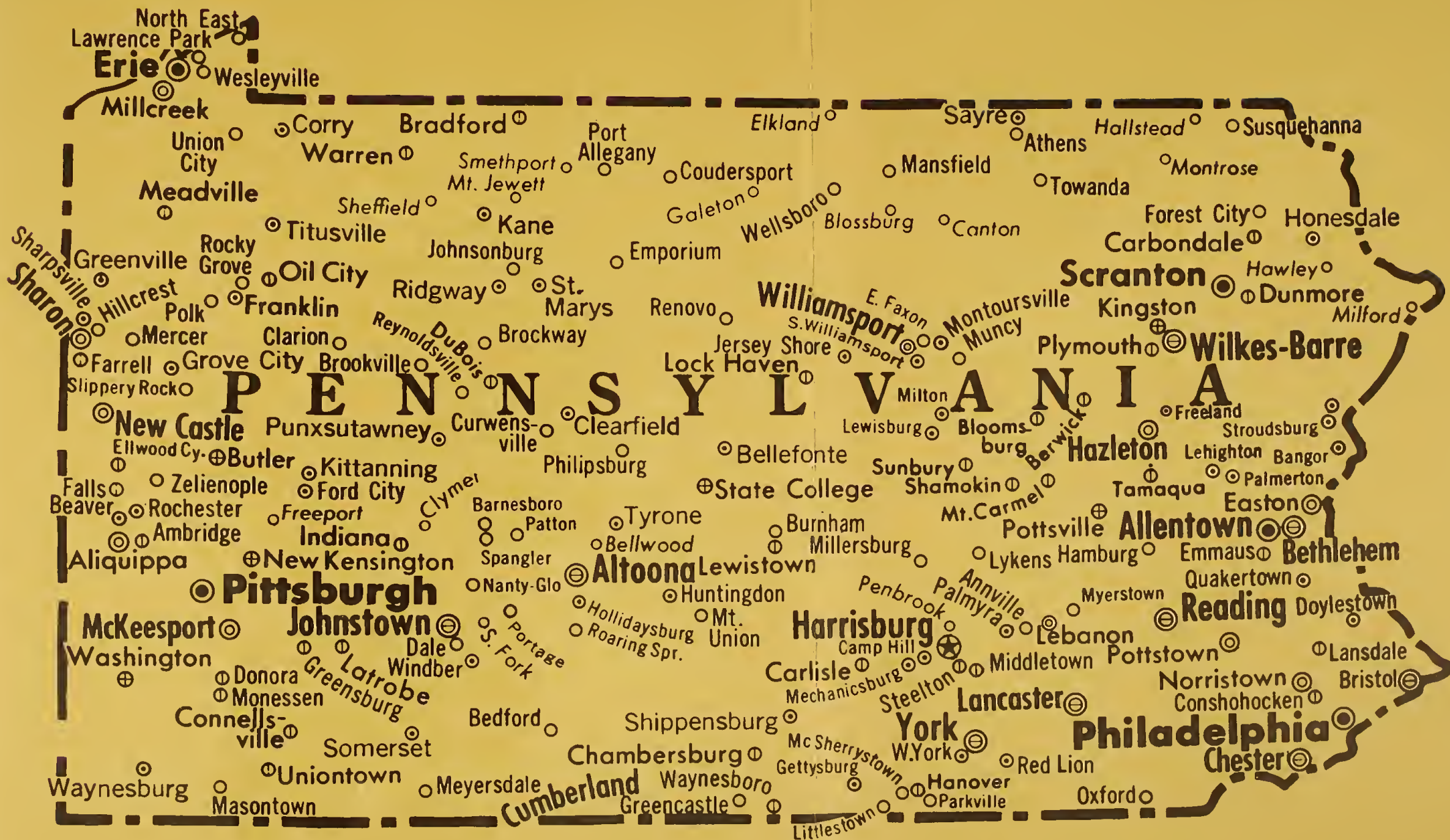
The current programs are on drug abuse in Pennsylvania.

Each subject is presented in two formats: as five separate five-minute "minidocumentaries," or as a single fifteen minute program.

The drug abuse documentary is narrated by David Small of the State Society staff and it includes interviews with Emil S. Trellis, M.D., of Pittsburgh; Martin D. Kissen, M.D., of Philadelphia; J. Thomas Millington, M.D., of Harrisburg; Douglas S. Thompson, M.D., of Pittsburgh; Carmela F. deRivas, M.D., of Norristown; John Archer, of Penn State University; the Reverend Frank M. Reynolds, of Rehrersburg; and Paul Schrode, M.D., of the University of Pennsylvania.

ACHROMYCIN® WORKS HERE

TETRACYCLINE



Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been re-

ported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanelles have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN® V
TETRACYCLINE CAPSULES

ACHROMYCIN[®] WORKS HERE

TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

The cost differential—inconsequential



LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

Dilantin® (diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anti-convulsant drugs.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored.

ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred. DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.

Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS

019R67



Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



newsfronts

New PMS President Man of Contrasts

Whether it sprouted pirates, clergymen or physicians, there was always a vigor about the Farrar family tree that grew a man who, Sept. 28, "walked the plank" to the highest office in Pennsylvania medicine.

This Farrar is named George Jr., and he becomes the 119th President of the Pennsylvania Medical Society in ceremonies in Pittsburgh.

Dr. Farrar, who lives in the Philadelphia suburb of Gladwyne, probably would feel better if he wasn't a history bug. Then he wouldn't have discovered a pirate ancestor while tracing the family tree back to the first secretary of the Jamestown Colony.

The Farrars more than atoned for the pirate by turning out a long line of clergymen and physicians. Besides, Farrar the pirate was hanged and dangles alone from that branch of the family tree.

Dr. Farrar's father was one of that line of clergymen but the new president of the 12,000 member medical doctors in Pennsylvania almost didn't become a physician. He wanted to—ever since reading a biography of Sir William Osler at the age of 14—but lack of finances seemed to make his dream impossible. Instead, he went to Wesleyan University, earned a Bachelor of Science Degree in chemistry and was hunting around for a way to study for his doctorate.

A family friend came along with financial help that allowed him to go to Johns Hopkins University School of Medicine where he ended up teaching his own pharmacology class.

There are more conventional aspects of Dr. Farrar's life. For instance, his internship and residency at the University of Michigan Hospital in Ann Arbor where he specialized in internal medicine. He was later certified by the American Board of Internal Medicine.

Then he became an associate pharmacologist with the Food and Drug Administration, assistant professor of medicine at Temple University School of Medicine, associate physician and then chief of medical service at Episcopal Hospital in Philadelphia. In 1940, along with enough responsibilities to keep two men busy, he became a consultant to the advertising department of Wyeth Laboratories in Radnor and nine years later joined its staff. Six years ago, Dr. Farrar was elevated to his present position as director of medical services at Wyeth.

The first thirty of Dr. Farrar's sixty-two years found George spending a big chunk of his time packing and unpacking. His Methodist minister father was seldom with one pastorate more than two or three years at a time and from his birthplace in Winter Park, Florida, George moved all over New England and to Maryland and Michigan before he finally settled down in the Philadelphia area with his wife, a registered nurse he had met in Michigan.

It's a rare sight to see Dr. Farrar without a lapel flower

invariably plucked from his own garden. A shock of white hair, still thick enough to become unruly, tops the tall physician who moves about with what seems to be a relaxed amble until you try to keep up with him.

He isn't afraid to say "I don't know" if asked a question in an area with which he is not fully acquainted, but such areas are extremely rare. Dr. Farrar was president of the Philadelphia County Medical Society four years ago. His involvement with the Pennsylvania Medical Society goes back twenty years and includes work with many of the committees and commissions that he now directs as President.

Dr. Farrar has squeezed out enough time for a host of civic responsibilities including such things as membership on the Executive Committee of the United Fund of Greater Philadelphia. He's also been an author and editor of many medical books and articles.

Along with all of this, Dr. Farrar brings a ready wit to the office of president, too. He's adept at turning aside wrath with soft or joking answers but he's as persistent as a Pennsylvania Dutchman despite his English ancestry. He has some hobbies, such as fishing, which he almost never gets a chance to do, and last summer he took a hectic ride down the Colorado River on a bouncing raft.

He had his family around him that Saturday night when his elevation to the presidency took place as the concluding event of the 119th annual session of the Pennsylvania Medical Society.

The Farrar's have a son and a daughter, neither of whom have followed in Dad's footsteps but then, who could?

Dr. Farrar Testifies On Fee Problems

During a hearing of the Governor's Advisory Committee on Mental Health and Mental Retardation, August 13, in Harrisburg, then PMS President-elect George E. Farrar, Jr., M.D., recommended to the Committee that a paragraph dealing with fees for physicians' services covered by Blue Shield is restrictive and should be eliminated from the proposed regulations—Title 5200 and 5300, County Mental Health and Mental Retardation Program.

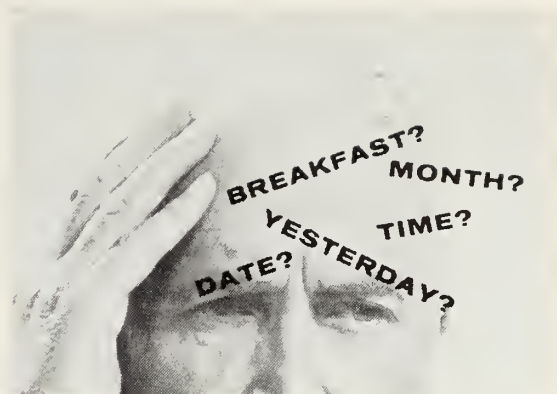
"All of the regulations on fees, other than paragraph 1.31," stated Doctor Farrar, "provide that fees shall be based on actual costs or reasonable charges.

"In contrast . . . 1.31 restricts fees for services covered by Blue Shield to the Blue Shield Plan A fee schedule." The effect of that paragraph's provision, according to Dr. Farrar, is to reduce such fees to approximately fifty percent of the prevailing fees for such services.

The position of the Pennsylvania Medical Society on this subject is well known to the Commonwealth for the Society has repeatedly pointed out that Blue Shield Plan A is a substandard fee schedule and the complete withdrawal of all fixed fee schedules has been advocated.

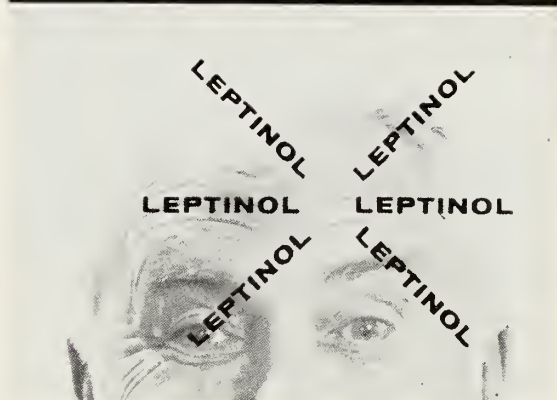
"It is apparent," said Dr. Farrar, "that the fee provision . . . would create a severe inequity to physicians supplying Blue Shield-covered services as compared to physicians supplying other than Blue Shield-covered services." The effect of this inequity is that a majority of physicians in this category would find it difficult to participate and that

(Continued next page)



When elderly patients display symptoms of apathy, mental confusion, memory lapses... consider

LEPTINOL®



LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses. It is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day. Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid. Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.



THE VALE CHEMICAL COMPANY, INC.
Pharmaceuticals Since 1922
ALLENTOWN, PENNSYLVANIA 18102



After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute-diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.



Parepectolin®

Each fluid ounce of creamy white suspension contains:

*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified) . . . (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

newsfronts

patients seeking care under the MH-MR Act of 1966 would be equated with Welfare recipients.

The Society's position in this matter is supported by the federal Department of Health, Education and Welfare which, in federal regulations dealing with the subject of reimbursement of physicians' services for the medically indigent and the medically indigent states: "The state, in determining the upper limits of reasonable charges, shall take into consideration the usual payments received by the providers for furnishing similar services from private patients, from intermediaries, and carriers for Social Security Administration, and from other third party insuring organizations for comparable services to regular policyholders and subscribers. In making payments, the state shall take into consideration the prevailing payments in the locality for similar services."

In conclusion, Dr. Farrar said he recognized that the hearing was not concerned with Title XIX, but that the Pennsylvania Medical Society is sincerely interested in the County Mental Health and Mental Retardation Program.

"We have hopes that this program will develop into a model for other states," said Doctor Farrar, "yet we are confident that its future will be jeopardized if the State elects to, once again, tie this program to an outmoded method of reimbursing physicians."

Tri-Hospital Program Aids Respiratory Diseased Children

Children with chronic respiratory diseases will now receive coordinated care under a joint program established by The Children's Hospital of Philadelphia, Hahnemann Hospital and St. Christopher's Hospital for Children.

Funded by the U.S. Public Health Service of the Department of Health, Education and Welfare in the amount of \$209,000, the program is believed to be the first of its kind.

According to the organizers of the project, the value of such a program to the patient lies in the sharing of diagnostic techniques, development of new treatments and ongoing consultation among the participating physicians and students.

Coordination of the program will be achieved through direction by a board of directors with a physician from one of the three hospitals as annual rotating chairman.

The board of directors will formally organize and implement the scheduling of shared educational experiences and provide facilities within the participating institutions as needed. A formally scheduled system of consultation among interns and residents will be inaugurated. Clinical fellows will be required to participate in all conferences, seminars and teaching programs organized for the three institutions.

Standardized diagnostic regimens and procedures will be developed Children's Heart Hospital in Philadelphia and Children's Seashore House in Atlantic City, both convalescent and rehabilitation facilities, will be utilized by the physicians. The new combined project is expected to run until June 30, 1971.

Ongoing studies will be made to measure the short and long term value of such a program in the community.

"Right there Mr. Fletcher, is your Vietnam!"



Your cartoon suggestions are invited for this series.

OBETROL[®] for weight control

Each OBETROL-10 tablet contains: Methamphetamine Saccharate 2.5 mg.; Methamphetamine Hydrochloride 2.5 mg.; Amphetamine Sulfate 2.5 mg.; Dextro-amphetamine Sulfate 2.5 mg.; (OBETROL-20 tablets contain twice this potency) Pat. #2748052.

This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperactive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

Dosage and Administration: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100, 500, and 1000.

REQUEST SAMPLES AND LITERATURE

OBETROL PHARMACEUTICALS • BROOKLYN, N.Y. 11207

DR. _____

ADDRESS _____

CITY _____ STATE _____

SIGNATURE _____

OBETROL PHARMACEUTICALS
Div. of Rexar Pharmacal Corp., Brooklyn, N.Y. 11207



close-up/MD's

An award-winning physician-pharmacologist who also has edited a book



DR. VESELL

on art has been named to the faculty of The Pennsylvania State University College of Medicine at The Milton S. Hershey Medical Center. The appointment of **Elliott S. Vesell, M.D.**, as professor and chairman of pharmacology and professor of genetics has been announced by **George T. Harrell, M.D.**, dean and director at Hershey.

Milton Graub, M.D., Philadelphia, has been re-elected president of the National Cystic Fibrosis Research Foundation and of its Eastern Pennsylvania, Southern New Jersey and Delaware Chapter, has been named to the President's Committee on Employment of the Handicapped and as a consultant to the Chronic Respiratory Diseases Control Program of the Department of Health, Education and Welfare.

Harry Bacon, M.D., attended the American Proctologic Society meeting held in Denver, Colorado, June 10th to 14th, 1968. He was the moderator on the panel, *Pull-Through Procedure, (What, How, Why)* and also guest speaker on *The Diagnosis and Management of Intestinal Fistula*.

Mildred C. J. Pfeiffer, M.D., director of the Division of Planning in the Pennsylvania Health Department, has been honored with a Distinguished Service Award from The Arthritis Foundation "in grateful recognition of outstanding service and support in the fight against America's No. 1 crippling disease." The award was presented to Dr. Pfeiffer at the national Foundation's recent 20th anniversary meeting in New York City.

Theodore L. Donmoyer, M.D., Allentown, has been appointed editor of the *Lehigh County Medical Society Bulletin*. **Luscia W. DiLeo, M.D.**, will remain on the *Bulletin* staff as associate editor.

Bruce Michael Morse, M.D., Philadelphia, received triple honors at the 121st commencement of the Hahnemann Medical College. Dr. Morse, who was one of the 101 to receive the degree of Doctor of Medicine, received the Dean's Award recognizing the highest average for the four years and was co-winner of the Charles Block Memorial Prize for demonstrated general excellence in medicine throughout the student and clerkship training, and claimed the Dr. and Mrs. D. Bushrod James prize for the highest average in Obstetrics and Gynecology. Co-recipient of the Block Award was **John Owens, M.D.**, Audubon, N.J.

Albert N. Brest, M.D., acting head of the section of cardiology and associate professor of medicine, Hahnemann Medical College and Hospital of Philadelphia was presented with the Christian A. and Mary F. Lindback Foundation Award at the Hahnemann Medical College's 121st commencement exercises. This award acknowledges and rewards outstanding teaching performance.

William S. Gibson, M.D. has been appointed an associate in the department of otolaryngology at The Geisinger Medical Center. The Florida-born physician completed both his internship and residency at the Danville medical complex. Following completion of his internship, he fulfilled his military service requirements in the U. S. Navy at the Main Navy Outpatient Dispensary, performing general officer's duties as well as specialized duties in the Ear, Nose and Throat Clinic.



DR. GIBSON

Carmela deRivas, M.D., Norristown, has been awarded the 1968 Citation of the Commonwealth Committee of the Woman's Medical College of Pennsylvania. Dr. deRivas is superintendent of Norristown State Hospital.

The appointment of **Robert T. P. deTreville, M.D.**, as president and chief administrative officer of the Industrial Hygiene Foundation of America, Inc., (IHF), has been announced by E. K. Davison, Chairman of the Foundation's Board of Trustees. Dr. deTreville has been a Senior Fellow of Mellon Institute and IHF's managing director since 1963.

Santo Longo, M.D. has joined the medical staff at The Geisinger Medical Center. The new associate in the department of pathology completed a four-year residency in clinical and anatomical pathology at the Pennsylvania Hospital in June. Part of his residency was spent



DR. LONGO

in the Institute for Cancer Research at Fox Chase working with tissue cultures and for the past three years he has been an assistant instructor in pathology at the University of Pennsylvania School of Medicine.

Alma Dea Morani, M.D., internationally known plastic surgeon and clinical professor of surgery at The Woman's Medical College of Pennsylvania, received the "Golden Lady, Woman of Achievement" award from the American Italian Awards Society during its 12th annual awards dinner in New York City. These "Amita" awards are given annually to American women of Italian ancestry who have distinguished themselves in the arts, business, professions or the armed forces. The Society also provides scholarships for worthy women students, regardless of race, creed or national origin, and has granted 100 scholarships since it was formed in 1956.

At the annual meeting of the Pennsylvania Allergy Association, the following officers were elected for 1968-1969: President, **Leonard S. Girsh, M.D.**, Philadelphia; President-Elect, **Martin L. Lee, M.D.**, Danville; Secretary-Treasurer, **Macy I. Levine, M.D.**, Pittsburgh.

Howard M. Pollack, M.D., has been appointed director of the department of radiology at Episcopal Hospital, Philadelphia. Currently, he is associate radiologist at the Rolling Hill Hospital and Diagnostic Center, Elkins Park. He assumed the post at Episcopal in September.

Burton Cahn, M.D., a psychoanalyst with extensive clinical and administrative experience, has been named director of psychiatric resident training for Philadelphia State Hospital at Byberry. Dr. Cahn, who has conducted widespread research on new drugs for the mentally ill, was previously director of residency training at Norristown State Hospital and an assistant professor of psychiatry at the University of Pennsylvania School of Medicine.

J. Mostyn Davis, M.D., Shamokin, has been elected permanent chairman for the five-county rural health study now under way in Columbia, Montour, Northumberland, Snyder and Union Counties. The project, which is sponsored jointly by the Pennsylvania Department of Health and the U.S. Public Health Service, is exploring rural health needs and facilities in the five-county area as a basis for future planning.

James J. Mowad, M.D., born and raised in Scranton, has returned to the Central Pennsylvania region as an associate in the department of urology at The Geisinger Medical Center. His subspecialty interests are in the field of renal hypertension and pediatric urology.



DR. MOWAD

From 1962 to 1964, he served in the U. S. Public Health Service and was assigned to the University of Pittsburgh.

Robert L. Lasher, M.D., Erie, has been promoted to captain in the US Naval Reserve Medical Corps. Ceremonies were held recently at the National Naval Medical Center in Bethesda, Md.

D. Ernest Witt, M.D., Bloomsburg, has been installed as president of the Pennsylvania Academy of General Practice. As president, Dr. Witt will serve as chief executive officer of the Academy and as chairman of the board of directors.

John T. Dickinson, M.D., Pittsburgh, served as seminar coordinator at a six-day post-graduate seminar on facial plastic and reconstructive surgery at the University of Wurzburg, Germany this past summer. Otolaryngologists from Germany, Switzerland, France



DR. DICKINSON

and Italy were invited to the seminar, the first of its kind for ear, nose and throat specialists in Western Europe.

Gordon W. Allan, M.D., recently director of special medical services for the Pittsburgh and Allegheny County Health Department, has assumed new duties as a Public Health Physician in the Pennsylvania Health Department's Division of Research and Biostatistics. In his new position, Dr. Allan will head a program of health services research being designed to complement new emphasis in this area by the U.S. Public Health Service. He will also work as a member of the Health Department's epidemiologic research team on a variety of studies being conducted in the Commonwealth.

Eugene L. Coodley, M.D., chief of medicine, (Hahnemann Division) Philadelphia General Hospital has been elected to Fellowship of the American College of Gastroenterology. He is currently a Fellow of the American College of Physicians and the American College of Cardiology.

James A. Collins, Jr., M.D., is the new president-elect of the Pennsylvania Society of Internal Medicine. His colleagues elevated him to this post during the group's annual meeting at Seven Springs. Dr. Collins is the director of the Department of Internal Medicine at The Geisinger Medical Center, Danville. He currently is the chairman of the Committee planning the convention program for the Pennsylvania Medical Society and is vice-chairman of its Council on Scientific Advancement.

Rex W. Green, M.D., Bethlehem, has been appointed corporate medical director for Mack Trucks, Inc. The new position will include responsibility for coordinating medical services and activities in the company's various departments and locations as well as developing new approaches to industrial medical management techniques.

Alfred M. Bongiovanni, M.D., physician-in-chief at The Children's Hospital of Philadelphia, has been elected to membership on the Council of the American Pediatric Society and also to the Council of National Pediatric Societies. Dr. Bongiovanni is professor and chairman of pediatrics in the School of Medicine of the University of Pennsylvania. He is a Fellow of the American Academy of Pediatrics.

John Esbenshade, Jr., M.D., has been named director of medical education at Lancaster General Hospital. Dr. Esbenshade succeeds **Henry Miller, M.D.**, who resigned recently to become a captain in the U.S. Navy Medical Corps.

J. Stanley Anderson, M.D., Pittsburgh, was honored as *Man of the Year* by the Penn Hills Amvets Post 73 at a Memorial Day Service. Dr. Anderson served as physician for the Universal Atlas Cement Co. for a number of years.

Robert E. Sass, M.D., has been elected president-elect of Northwestern Pennsylvania Chapter, American College of Surgeons.

Norman L. Ekberg, M.D. has been appointed an associate in the department of internal medicine at The Geisinger Medical Center. He goes to GMC following a two-year tour of duty in the U. S. Public Health Service. His assignment was with the Philadelphia Department of Public Health in the Heart Disease Control Program.



DR. EKBERG

At the 116th Commencement exercises of Woman's Medical College of Pennsylvania, **Ann Gray Taylor, M.D.**, Germantown and **Maryesther Burns, M.D.**, Selinsgrove, were honored by Woman's with the presentation of gold pins to mark the 50th anniversary of their graduation from the College.

Norman Makous, M.D., Philadelphia, spoke at a special seminar of the International Society of Cardiology's Rehabilitation Council at the Mediterranean Hotel, Cagliari, Sardinia, Italy.

Melvin C. Williams, M.D., Indiana, has been elected to membership in the American Society of Internal Medicine.

(Continued next page.)

close-up/MD's

Lowell Lane, M.D., professor of medicine, Hahnemann Medical College and Hospital, was cited by the Hahnemann Alumni Association for "his eminence in cardiology, his unswerving selfless devotion to his patients and his school, and for the honor which he has brought to his profession." A 1928 graduate, Dr. Lane was honored at the annual alumni reunion banquet at the Bellevue Stratford Hotel. The Alumni Association presented the college with a portrait of **Charles S. Cameron, M.D.**, who was dean of the college from 1956 to 1961 and is currently president of the corporation. Dr. Cameron is a member of the Hahnemann class of 1935. **Alex E. Pearce, M.D.**, class of 1937, and chairman of the Alumni Board of Trustees made the presentation. **Harry K. Gabroy, M.D.**, class of December '43 and **William R. Solami, M.D.**, class of March '43, who are the out-going co-presidents of the Alumni Association were honored. **Benjamin Calesnick, M.D.**, class of 1944, was installed as the new president of the 4,000 member association. Dr. Calesnick is professor of pharmacology and head of the section of human pharmacology, at Hahnemann.

John A. Hargleroad, II, M.D., a staff physician at the Ritenour Health Center of The Pennsylvania State University, has been named director of the Center. He succeeds **Albert L. Ingram, Jr., M.D.**, who resigned to become mental health commissioner of Delaware.

Walter H. Comer, M.D., **Robert E. Laurie, M.D.**, **Earl T. Lewis, M.D.**, and **John Silverio, M.D.**, have been appointed to newly created positions on the medical staff at Wyeth Laboratories. Drs. Comer, Laurie and Silverio, each named associate director—clinical investigation, will report to **Robert J. Bower, M.D.**, assistant medical director—director of clinical investigation, as will Dr. Lewis, who was named associate director—medical communications.

Elizabeth S. Waugh, M.D., clinical professor of gynecology and obstetrics, The Woman's Medical College, delivered a paper on *Methods of Birth Control* before the Congress of the Medical Women's International Association in Vienna. Physicians from

many countries came together to consider the theme, *The Hungry Millions—How to Prevent the Population Explosion*. Dr. Waugh also served as a councilor.

Elmo J. Lilli, M.D., and **Joseph P. Viglione, M.D.**, Stroudsburg, have been reelected to three-year terms as members of the American Academy of General Practice.

J. Norman White, M.D., Scranton, was honored recently with the dedication of the Dr. J. Norman White Infirmary at the YMCA of Greater Scranton's Camp Spruks in recognition of his many years of service to Scranton youth.

James H. Parker, Jr., M.D., Reading, is serving aboard the hospital ship *S.S. Hope* for a two-month tour in Ceylon.

George E. Farrar, Jr., M.D. has been named chairman of the U.S. Savings Bonds Drive. Dr. Farrar is director of medical services for Wyeth Laboratories of Philadelphia.

Jack Fairweather, M.D., Lewisburg, has accepted the chairmanship for the planning committee seeking to establish a community mental health association in Union County.

Raymond J. Lantos, M.D., Johnstown, has been elected a Fellow in the American College of Physicians. Dr. Lantos is chairman of the department of medicine at Memorial Hospital where he is a member of the executive committee of the medical staff.

Philip Schwartz, M.D., director of the Warren State Hospital pathology department, was honored by the American College of Obstetricians and Gynecologists at its Annual Meeting for his presentation of research work.

Officers of the Pennsylvania Psychiatric Society for 1968-1969 include: **James T. McLaughlin, M.D.**, Pittsburgh, president; **Jack B. Kremens, M.D.**, Haverford, president-elect; and **William A. Phillips, M.D.**, Philadelphia, secretary-treasurer.

Officers and directors of the Pennsylvania Radiological Society for 1968-69 include: president, **Roderick L. Tondreau, M.D.**, Meadowbrook, president-elect, **Frank R. Kinsey, M.D.**, Lewistown; first vice-president, **New-**

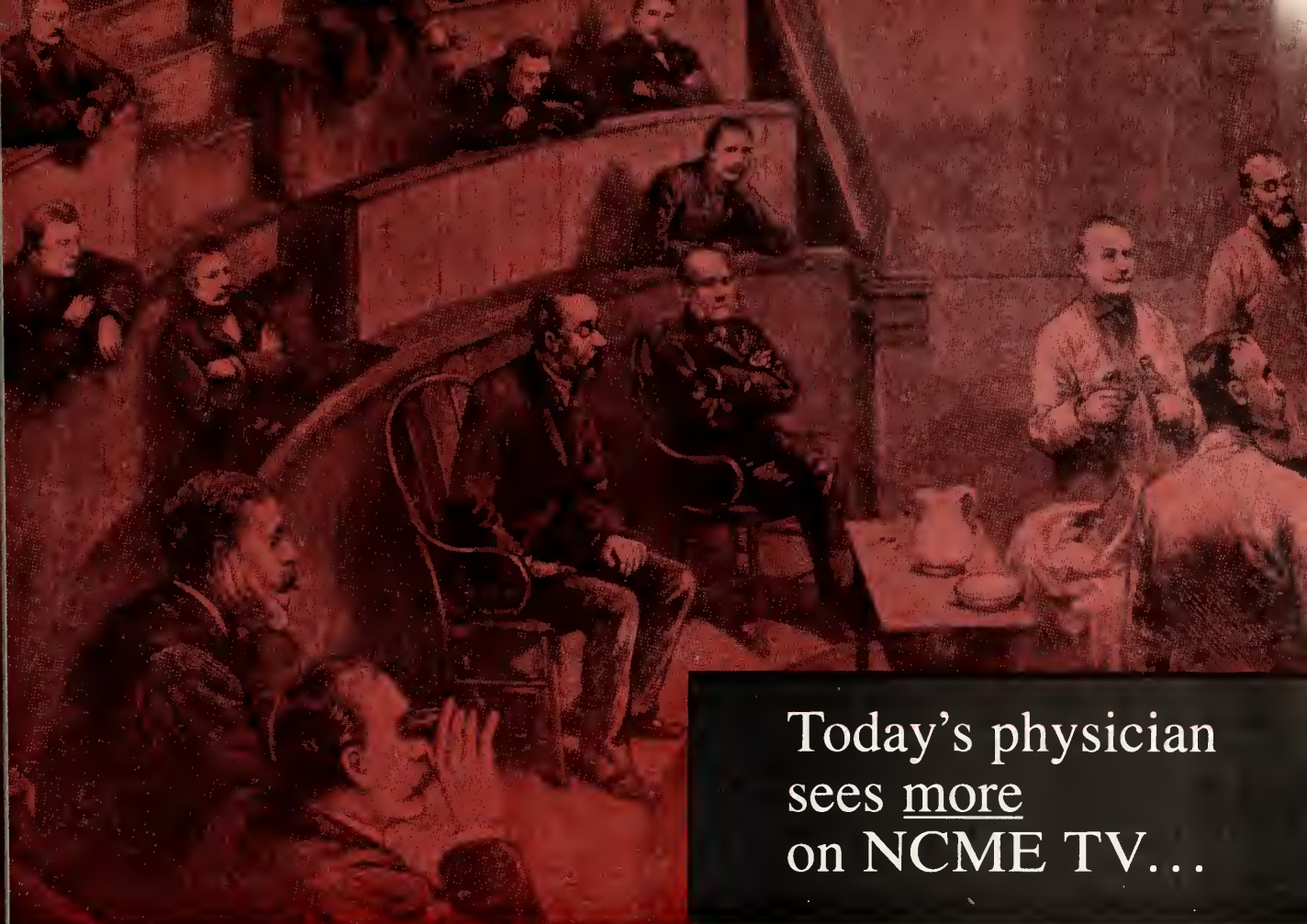
ton Hornick, M.D., Pittsburgh; second vice-president, **Thomas A. Campbell, M.D.**, York; secretary, **Theodore A. Tristan, M.D.**, Harrisburg; treasurer, **Roy R. Greening, M.D.**, Philadelphia; editor, **Marlyn W. Miller, M.D.**, Altoona; councilor to the American College of Radiology, **John H. Harris, Jr., M.D.**, Carlisle; alternate, **Edgar L. Dessen, M.D.**, Hazelton; directors, **David A. Huot, M.D.**, Pittsburgh; **Herman C. March, M.D.**, Philadelphia; **Fred S. Winter, M.D.**, Pottstown; **Erwin Beck, M.D.**, Pittsburgh; **Joseph J. O'Brien, M.D.**, Scranton; **William J. Tuddenham, M.D.**, Philadelphia; **Donald G. Ferguson, M.D.**, Pittsburgh; **Paul S. Friedman, M.D.**, Philadelphia; and **T. Frederick Weiland, M.D.**, Grove City.

Robert L. Brent, M.D., professor and head of the department of pediatrics, and **Robert C. Mackowiak, M.D.**, assistant professor of physiology at Jefferson Medical College, have been awarded Christian R. and Mary F. Lindback Awards for Distinguished Teaching.

S. Leon Israel, M.D., has been elected president of the Professional Staff at the department for sick and injured, Pennsylvania Hospital. He is Director of the Division of Obstetrics and Gynecology. Also appointed at the recent elections were: vice president, **Mario V. Troncelliti, M.D.**, director of the department of anesthesiology; and secretary-treasurer, **William J. Tuddenham, M.D.**, director of the department of radiology. The new president of the Medical Staff at the Institute, the Hospital's psychiatric department, is **William E. Kelly, M.D.** **Don E. Johnson, M.D.** is vice president, and **Howard B. Smith, M.D.**, is secretary-treasurer. All three are senior attending psychiatrists.

Matthew R. Hadley, M.D. has been elected to the board of trustees of the Tuberculosis League of Pittsburgh. Dr. Hadley is a member of the PMS Commission on Environmental Health.

Harold O. Closson, M.D., Gettysburg, returned recently from a ten-week tour of duty at the Lady of Palms Hospital on the Isle of Turtles. Dr. Closson assisted at the Hospital under the auspices of the Catholic Medical Mission Board.



Today's physician sees more on NCME TV...

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME

The Network
for Continuing
Medical
Education

NCME TV Offers These Practical Benefits:

- ☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.
- ☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.
- ☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.
- ☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.
- ☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N. Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N. Y. 10017

An anorectic will help her lose weight—
but can she keep it off?
You need more than a pill
(even ours) to do that!



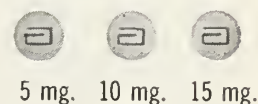
That's why Abbott offers
you a pill plus a program.



The Product

*For smooth appetite
control plus mood
elevation*

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

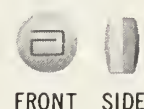


*For patients who can't
take plain amphetamine*

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



*Please see Brief Summary
on next page.*

Ask Your Abbott Man For Free Supplies

801444

Brief Summary

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society
in recent months:

PHILADELPHIA COUNTY:

- STANLEY J. DUDRICK, M.D., 3400 Spruce Street, Philadelphia 19104.
CLAUDIUS A. R. ELCOCK, M.D., 400 South 57th Street, Philadelphia 19143.
ZORAN CUPIC, M.D., Jefferson Hospital, Philadelphia 19107.
JAMES E. MARRONI, M.D., 14006 Napier Street, Philadelphia 19116.
GEORGE J. NICHOLS, M.D., 1 Parkway, Philadelphia 19130.
FRANCIS W. PEDROTTY, JR., M.D., 8151 Revere Street, Philadelphia 19152.
H. SHAFIA, M.D., 1226 East Hunting Park Avenue, Philadelphia 19124.
HOWARD WEINBERG, M.D., Ford Road and Monument Avenue, Philadelphia 19131.
ALBERT L. LAMP, JR., M.D., 99 Foxcroft Drive, Doylestown 18901.
WILLIAM B. CASKEY, M.D., 903-B Park View Apts., Collingswood, N.J. 08107.
EUGENE COHEN, M.D., 3701 Academy Road, Philadelphia 19154.
DONALD FAUST, M.D., 128 Country Club Road, Willingboro, N.J. 08046.
PAUL R. GROSS, M.D., 742 Suffolk Road, Jenkintown 19046.
ROBERT F. JOHNSTON, M.D., 230 North Broad Street, Philadelphia 19102.
HERMAN BLACK, M.D., Graduate Hospital of Univ. of Pa., 19th and Lombard Streets, Philadelphia 19146.
JAMES P. BOLAND, M.D., 3300 Henry Avenue, Philadelphia 19129.
ELEANOR O. LEISE, M.D., 433 Haverford Road, Wynnewood 19096.
HAROLD I. LIEF, M.D., 191 Buck Lane, Haverford 19041.
WILLIAM J. MCENTEE, M.D., 230 North Broad Street, Philadelphia 19102.
ANTHONY W. SALEM, M.D., 1074 Delene Road, Rydal 19046.
NORMAN J. SCHATZ, M.D., 515 Plymouth Road, Apt. B7, Plymouth Meeting 19462.
JACOB SCHUT, M.D., 173 Edgehill Road, Bala-Cynwyd 19004.
BERNARD SIGEL, M.D., 3300 Henry Avenue, Philadelphia 19129.
PETER SIGMANN, M.D., 230 North Broad Street, Philadelphia 19102.
GEORGE B. SMITH, M.D., Apt. 608 Chetwynd, Rosemont 19010.
ALPTEKIN UCMAKLI, M.D., 6901 Old York Road, Philadelphia 19126.
ANTONIO VALDES-DAPENA, M.D., Graduate Hospital, Philadelphia 19146.
DAVID K. WAGNER, M.D., 3300 Henry Avenue, Philadelphia 19129.
HOWARD ZEIDMAN, M.D., 230 North Broad Street, Philadelphia 19102.

W. J. RUSSELL TAYLOR, M.D., Philadelphia General Hospital, Philadelphia 19104.
 MERYLEE E. WERTHAN, M.D., 3214 North Broad Street, Philadelphia 19140.
 LOUIS SOSCIA, M.D., 1348 Sharpnack Street, Philadelphia 19150.
 HERBERT STEIN, M.D., Oak Summit Apts., 310 Easton Road, Glenside 19038.
 STANFORD M. STEINBERG, M.D., 207 Pelham Road, Philadelphia 19115.
 VICTOR L. TORRES, M.D., 121 West Walnut Lane, Philadelphia 19144.
 JOHN W. BEEM, M.D., 6852 Clover Lane, Upper Darby 19082.
 MYRON L. BLUMBERG, M.D., 2015 Spruce Street, Philadelphia 19103.
 WILLIAM J. BRENNAN, JR., M.D., 287 Meeting House Lane, Merion Station 19066.
 ROBERT E. CANTOR, M.D., Park Drive Amnor Apts., Philadelphia 19144.
 DAVID CHOMSKY, M.D., 8120 New Second Street, Philadelphia 19117.
 PETER E. FARRELL, M.D., 3408 Rhawn Street, Philadelphia 19136.
 VANIDA KIRDNOONWONGSE, M.D., 208 South 41st Street, Philadelphia 19104.
 CHARLES C. PARSONS, M.D., 310 Conshohocken State Road, Gladwyne 19035.
 JACK E. PICKERING, M.D., Wyeth Laboratories, P.O. Box 9299, Philadelphia 19101.
 FRANCIS E. ROSATO, M.D., 4300 Spruce Street, Philadelphia 19104.
 S. BRUCE RUBIN, M.D., 1240 East Washington Lane, N.E., Apt. E28, Philadelphia 19138.
 ENRIQUE B. SILLA, M.D., 3751 Woodland Avenue, Drexel Hill 19026.
 CHARLES G. BLUMSTEIN, M.D., Temple University Hospital, Philadelphia 19140.
 RUDOLPH C. CAMISHION, M.D., 1101 Cherry Lane, Riverton, New Jersey 08077.
 STANLEY M. K. CHUNG, M.D., 3400 Spruce Street, Philadelphia 19104.
 STEPHEN L. CORSON, M.D., 1012 Spruce Street, Philadelphia 19107.
 CARL HAMMER, M.D., 221 Rodney Circle, Bryn Mawr 19010.
 FRANCIS M. JAMES, M.D., 402 Arthur's Round Table, Wynnewood 19096.
 JAMES LEE, M.D., 230 North Broad Street, Philadelphia 19102.
 JAMES R. McLAMB, M.D., 2401 North Broad Street, Philadelphia 19140.
 RENATO J. NARDINI, M.D., 262 Indian Creek Road, Philadelphia 19151.
 JOEL J. NOBEL, M.D., 2006 Delancey Place, Philadelphia 19103.
 JOSEPH P. O'RIORDAN, M.D., N.E. Medical Center, Suite 18, Philadelphia 19114.
 GIL E. PABLO, M.D., 420 Vernon Road, Jenkintown 19046.
 EUGENE L. COODLEY, M.D., Philadelphia General Hospital, Philadelphia 19104.

WYOMING COUNTY:

ARTHUR W. SHERWOOD, M.D., 133 North Bridge Street, Tunkhannock 18657.

OCTOBER, 1968



painful night leg cramps...

respond to specific therapy with QUINAMM™
 (Quinine sulfate, 260 mg., Aminophylline, 195 mg.)

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
 DIVISION OF RICHARDSON-MERRELL INC.
 PHILADELPHIA, PENNSYLVANIA 19144

no gaço



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:

Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.

(Warning: May be habit forming)

To reduce hypermotility and frequency.

Homatropine Methylbromide... 0.15 mg.

A safe dose for mild spasmolysis to curb cramping and griping.

Pectin... 24. mg.

Demulcent, adsorbent. Helps form stools.

Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID



INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action — analgesic, decongestant and antihistaminic — is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults — 2 tablets every 4 hours.

Children (6-12 years) — ½ the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Source of Symptomatic Relief

Sinutab® | 2 tabs. q.4h.



WARNER-CHILCOTT

MORRIS PLAINS, N.J.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



For headache, a sovereign remedy was to wear a snakeskin round one's head.



The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

**A realistic
approach
to pain
relief**

Empirin'[®]

**Compound with Codeine
Phosphate gr. 1/2 No. 3**

Each tablet contains:

Codeine Phosphate gr. 1/2 (Warning—
May be habit forming), Phenacetin gr. 2 1/2,
Aspirin gr. 3 1/2, Caffeine gr. 1/2.

**keeps the promise
of pain relief**

W. & Co.' narcotic products are
Class "B", and as such are available on oral
prescription, where State law permits.

 **BURROUGHS WELLCOME & CO. (U.S.A.) INC.**
Tuckahoe, N.Y.



New

Tegretol[®]

carbamazepine

Warning

Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.

Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.

Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long as a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.

Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.

Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.

In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.

Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect. Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.

Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.

Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.

Before initiating therapy, the following laboratory procedures should be performed:

1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.

2. Baseline evaluations of liver function.

During treatment with Tegretol, the following laboratory procedures should be performed:

1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.

2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.

3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.

4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.

Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.

Dosage and Administration The drug should always be taken with meal if possible.

Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. a 1200 mg. per 24 hours may be necessary.

Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.

At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.

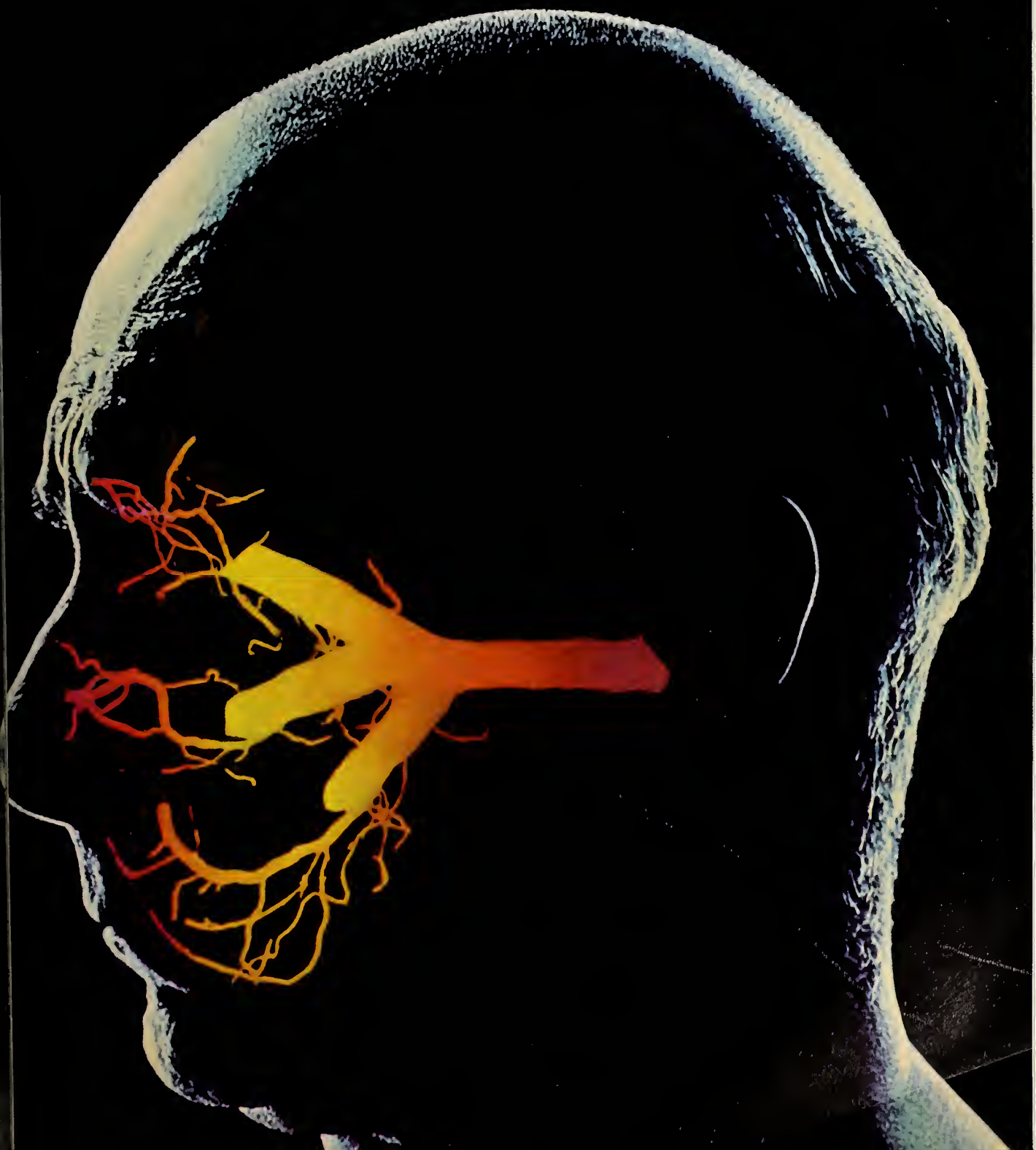
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000.

For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geigy

uncommon relief of
uncommon pain



The “
Divorced
Depressive: Forty
Forgotten

“Had a large wedding.”
“Had a fine home and family.”



Forlorn"

"ad a divorce."
m a real loser,
nd so are
he kids."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy—the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil[®] imipramine
hydrochloride
Geigy

in depression



Tofranil®, imipramine hydrochloride

Indications: Tofranil is recommended for the treatment of depressive states of diverse psychopathology.

Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.

Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.

Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure. In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.

The drug is not recommended at the present time in patients under 12 years of age.

Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and

Tofranil® Geigy

imipramine
hydrochloride

vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).

Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.

A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.

Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

Announcing the blood chemistries anyone in your office can do. Those using Diagnostest* reagents and instruments. We train your nurse or medical assistant to use this simple, accurate system. For measuring hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. You get results in minutes. And the system includes everything you need. Write today for full information.

*Trademark of The Dow Chemical Company





Your Stake In Elections And What You Can Do

As businessmen and community leaders, we have a particularly large stake in the coming elections and can play a critical role in their outcome.

Officials at all levels elected in November will, to a large degree, influence the solutions to many of the great problems confronting our communities, the Nation and the world around us.

I'm sure you are aware of them: inflation, soaring taxes, urban blight, racial tensions and riots, breakdown of law and order, poverty, hard-core unemployment, air and water pollution, strikes, and others.

Elected officials can also affect your business directly. In Washington, some sixty agencies have the power of decision over business activity. State and local officials can decide how and where you may operate your business, as well as tax. And don't forget: labor unions are out to regain losses of union friends in Congress suffered two years ago.

What can you do? As an executive, you have a dual responsibility to lead as well as be personally active.

As an employer, you can create an atmosphere of

political awareness among your employees. Keep them informed on the vital issues, especially those that affect your business and their jobs. A discussion course, such as the National Chamber's Action Course in Practical Politics, can be helpful in motivating employees in political involvement.

You can encourage your associates to contribute their skills in behalf of the candidates of their choice. Candidates always have use for speech writers, public relations men, artists and others with special skills.

As an executive, you possess talents in organization and management that equip you to serve on one of your candidate's committees—perhaps for fund raising or another key committee.

Remember, there are special interest groups, including labor unions, in the political arena, too. Remember, as well, that better government will create a better business climate. The way to get it is for more business and professional people to participate in the political process.

Winton M. Blount

President, Chamber of Commerce of the United States

Nobody Votes In My Town

(Editor's Note: At a time when the medical profession stands at a crossroads in its splendid history of service to mankind and it is faced with the choice of several avenues to bright or ominous tomorrows, the right to vote becomes a strategic vehicle. Never before has this freedom of expression been so important to any single group. The author of the following article, and associates in his group, cannot vote. PENNSYLVANIA MEDICINE was interested to know how he felt about this deprivation. You will be, too.)

As another presidential election day approaches, probably never before was so much at stake in America. But most of my 3,700 townsmen apparently are chronic misfits who couldn't care less. My town is "Jacktown"—Southern Michigan Prison, near Jackson.

Now, in the morning chow line, a young murderer and a middle-age burglar come close to blows in an argument on the merits of the Republican Party. An alert guard breaks it up just in time.

The burglar is serving his fifth term in my town. I know him well. So, after he cools off, I needle him a bit, saying, "I take it you'd vote Democratic."

He scowls and says, "Hey, man—I never voted in my life. I've got sense enough to know no matter who gets elected, the best John Q. Public's gonna get is the

worst of it. The hell with votin'!"

That's seditious philosophy, isn't it? "The hell with votin'!" means down with democracy, your country, your government and, consequently, every home (where government really begins) in the land.

Yet, I have been guilty of comparable "sedition." It came out disguised something like this: "Didn't get around to voting; had too many other things to do on election day." The reflection lures me into deep concern and holds me down with this hard and heavy fact: I have been stripped of my voting rights for many elections to come.

I begin to wonder how my neighbors feel about not being allowed to vote. Later, I question nearly 300 of them. Almost 90 percent merely shrug or otherwise

(Continued on page 45)

capitol report

indicate lack of concern. Eighty individuals admit that they'd never voted! (Could the deeds that landed us here be germane to such disregard for democracy?) Consider three responses to: "Did you vote regularly when you were free?"

Gambling syndicate underling (age thirty-three, serving five to ten years): "The organization always saw to it that I voted; even told me who and what to vote for."

Alcoholic (doing one to two for non-support): "They'd let me off work in time to make it to the polls, all right. But I'd stop at a buddy's house to talk the election over. There'd be a bottle or two around. And somehow, before I considered all the issues and candidates and decided who'd get my vote, it was too late or I was too loaded to care any more."

Vote fraud fall-guy (age seventy-two, serving one and one-half to two years): "Election days was gravy days for me. I always voted. Got five bucks a ballot. Sometimes I made as much as fifty-five or sixty dollars."

As for me—well, occasionally it is difficult to face the mirror of patriotism and like what you see. Instead

of voting, I have gone hunting and fishing; attended to personal matters of assorted kinds. But the future will offer opportunities to prove my determination never again to skip a chance to vote.

In the meantime, what about you?

Like many other sheer blessings in our full-fashioned freedom, the privilege of voting just can't completely be appreciated until it is lost. I know. So I must agree with the immigrant who said: "Americans can't adequately appreciate their system of government because they don't understand what it ain't."

However, our Star Spangled Banner waves best when every thread is intact. Similarly, the government it represents needs every vote.

But nobody votes in my town. Nobody may.

What could be worse, patriotically?

—Your town, where every adult may vote . . . and you don't.

Pete 87776 Simer
4000 Cooper St.
Jackson, Mich. 49201

Campaign Platforms Cite Importance of Private Enterprise in Government Health Programs

Both the Democratic and Republican 1968 national campaign platforms cited the importance of the role of private enterprise in the development of government health programs. The GOP placed greater emphasis on private medicine than the Democratic party did.

"While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner," the Republican plank said.

The Republican platform also pledged "to encourage the broadening of private health insurance plans," including extension to cover mental illness.

"Through a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of medicare care," the Democratic platform said.

Without being specific, the Democrats indicated support for universal government health insurance or, at the least, wide expansion of Medicare or Medicaid (or both). Boasting of "giant steps" in the past eight years "in assuring life and health for its citizens," their platform said: "We Democrats are determined to take those final steps that are necessary to make certain that every American, regardless

of economic status, shall live out his years without fear of the high costs of sickness."

The Democratic health plank also said medical costs could be lowered by more out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers, and the greater use of sub-professional aides.

The Republican platform said "inflation produced by the Johnson-Humphrey Administration" was a major factor in the increases in health care costs.

American Medical Association spokesmen appeared before the platform committees of both parties at pre-convention hearings. Donald E. Wood, M.D., Indianapolis, Ind., chairman of the AMA's Council on Legislative Activities, testified at the Republican hearing; John R. Kernodle, M.D., Burlington, N. C., a member of the AMA Board of Trustees, at the Democratic. Their statements were the same.

The AMA statement expressed hope that the next federal Administration, whether it be Democratic or Republican, "will provide men and women in medicine, and those engaged in the allied sciences, the opportunity to think and work in a free atmosphere to pursue their common goal of a better and more healthful life for everyone."

Do you have patients who try to hide fear behind bravado?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

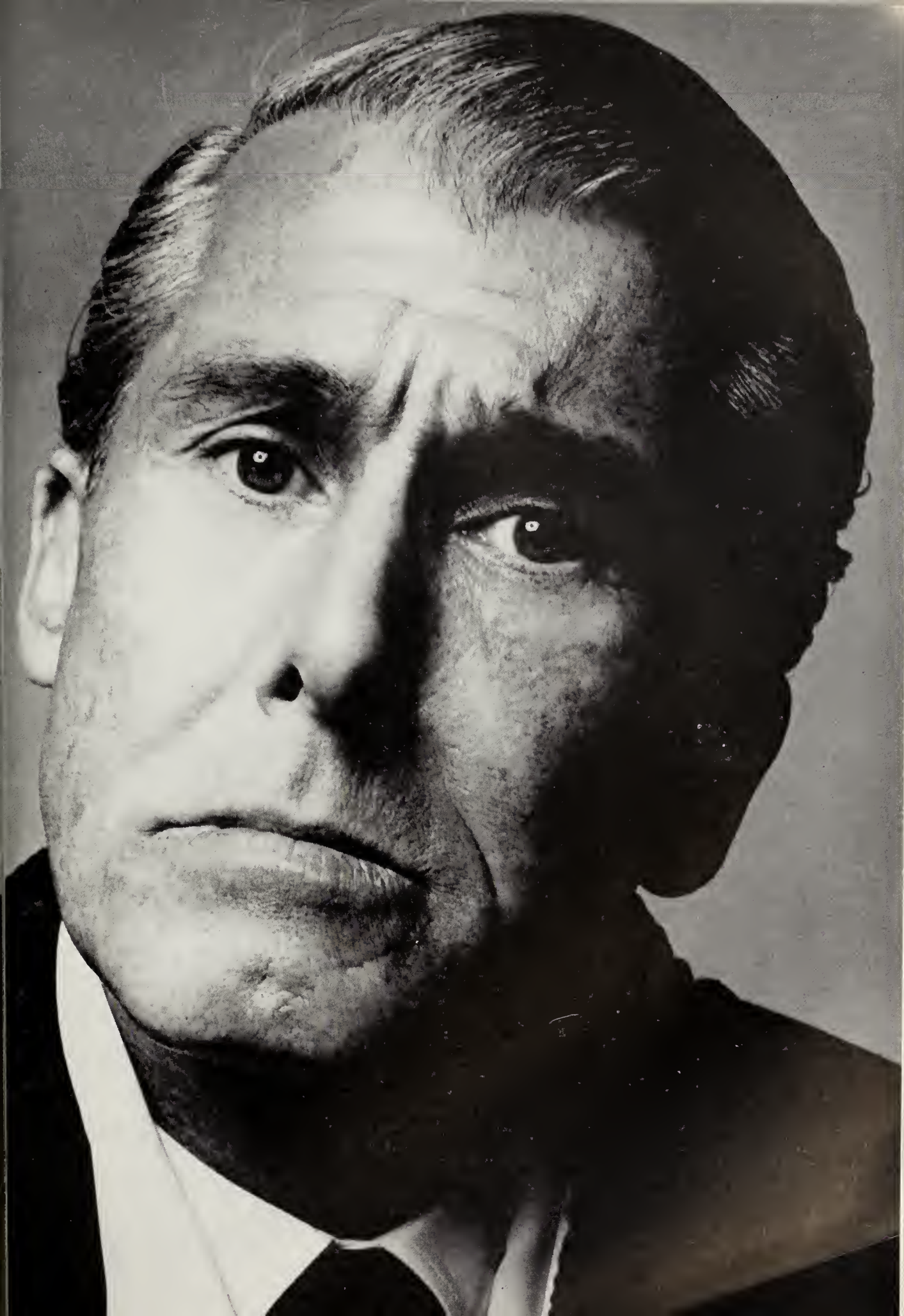
They want your help and Aventyl HCl can help you. Whether depression is open or secretive, Aventyl HCl assists you in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.

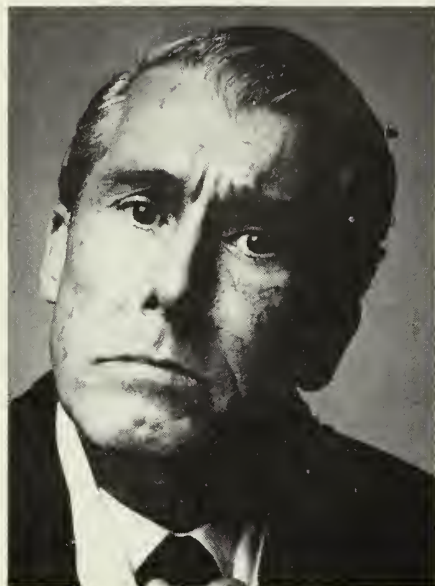


Eli Lilly and Company
Indianapolis, Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline Hydrochloride





Aventyl[®] HCl

Nortriptyline Hydrochloride

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two months after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic pur-

pura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl[®] HCl (nortriptyline hydrochloride, Lilly) under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules[®] or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily

10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily

10 mg.—Ages three to six, 1 Pulvule one to three times daily

Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily

Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl[®] HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500.

Additional information available to physicians upon request.



Eli Lilly and Company
Indianapolis, Indiana 46206

[OR1609]
800308



Are You Listening?

The Federal Government Is Talking To You, Doctor . . .

The past two Congresses, the 89th and the 90th, have passed a group of public laws that are going to vitally affect every physician in this country. We are all aware of Medicare legislation, but what many of us are not aware of is the scope and depth of other legislation that will eventually permeate every element of medical practice.

The American Society of Internal Medicine, a socio-economic organization, has through a group of dedicated officers, trustees, and committee chairmen investigated in depth all aspects of Federal legislation. This editorial summarizes some, but not all, of the findings of this organization. The efforts of major legislation which has become public law during the last two sessions of the Congress are examined.

The Federal Government is saying a number of things, and rather than delineating the cut and dried particulars of these various laws, an effort will be made to present the implications.

First and foremost Uncle Sam has told us, in no uncertain terms, that health is a birthright and not a privilege. This is not arguable and we are going to have to accept it whether we like it or not. Public discussion on this matter is certainly not to our best interest and should be meticulously avoided.

The Government is telling us that it will move in on any vacuum in quality health care. The problem, of course, is how to decide when a vacuum exists. Also, what may be quality health care in one portion of the Commonwealth might not necessarily be regarded in the same light in another part of the state. Thus, "quality care," unless it is going to be imposed from above, is a variable matter.

The Government also tells us that it wants a partnership between the private and the public sector. However, to have a true partnership there must be give and take on both sides. The tendency has been for the Government to give rather generously but then to dictate the terms.

The Government says that it wants buffers between Washington and the patient. However, it is difficult to say whether it is really a buffer or just a clerical intermediary. This may be due to the realization on the part of the Government that there are enormous complexities in establishing an administrative device that will render the proper care. These really may be temporary

devices until the Government can step in and take over by creating another tremendous increase in Federal employment with its consequent political implications.

The Government also says that it wants the state to get an active role, but the law is loosely worded. It may well be that here, again, this is a temporary device and if the states do not satisfy the Federal Government in administering these laws the Federal Government will gradually move in and administer it from Washington.

The Government says that it wants not only the responsibility but is willing to pay a major part of the cost and in many of the laws the entire cost. The question is, does Uncle Sam have a bottomless barrel of money? Many states have found to their discomfiture that they have had to limit the extent and degree of services because of the tremendous budgetary problems.

The Government says it wants the medical profession to be involved in quality control. Again, this must be done on a local level and any attempts to impose quality control from above are going to meet with an extremely complicated reaction. If quality control in the hospital is difficult, quality control in the office is virtually impossible, but this may not stop the Government from trying.

On top of this, the Government says it wants the medical profession to be involved in cost control. However, will the Government recognize how expensive real quality is and will they continue to be willing to pay for it? An excellent analogy is in transportation. You can ride to work in an old jalopy or in a Cadillac, but if you try and go out and buy a Cadillac at jalopy prices something has to give.

Recently the attitude toward the medical profession has changed because the Government has come to the realization that it cannot implement these programs without our assistance. This presents a golden opportunity to us and it becomes extremely important for us to involve ourselves to make these programs medically and scientifically adequate.

The Government says it wants us to have reasonable and customary fees. There is a gnawing suspicion, however, that this is what they are saying for the present and that they are throwing us a bone to allay our suspicions. Even today we see occasional comments by political person-

(Continued next page.)

editorials

ages in the press that medical care is too expensive.

What can we predict for the future between the Government and the practice of medicine?

The Government states that it does not want to interfere with private practice. At the same time, however, it is involved in all sectors of medical care. It seems that this involvement is going to progress and that private practice will diminish.

Despite the high quality of medical care in this country today the Government is telling us that if we do not do as good a job or better it is going to step in. This, despite the fact that the United States probably has one of the highest levels of medical care in the world. The health-care voter is very sympathetic when he is told that the Government is going to get him better medical care and he is willing to vote for the politicians who offer him more of everything.

One of the big problems in the administration of Government medicine is the buffers or financial intermediaries. They are frequently not sympathetic to the patient or the physician's needs. These buffers may not be as desirable as they first were when they were an absolute necessity. Unless they become more functional they may find that the Government will step in and take over. The intermediaries and the physicians have many things in common and better liaison is urgently needed. The practice of the intermediaries of letting some minor clerk make vital decisions is going to have to stop and more practical methods of handling physicians' and patients' complaints are going to have to be found.

The laws having to do with health care have been written so that the consumer is going to have a greater participation in the management of medical care in the future. For this reason, it is of the utmost importance that we get consumer participation that is knowledgeable and sympathetic to the practice of good medical care. Many of the laws have been written requiring 51 percent representation of the consumer on governing boards. There is no mention of the physician at all despite the fact that the chief concern of the law is with some aspect of the rendering of medical care to a portion of the population.

The role of the hospital is apparently going to

change considerably. Hospital care up to the present has been almost exclusively related to horizontal people—the ones lying in bed. There has been a neglect of the vertical people (those not hospitalized), and it is becoming apparent that the hospitals are going to involve themselves more and more in these areas with the aid and connivance of the Government.

Quality care must be rendered. If today's physicians render high quality care and keep the consumer-patient satisfied, they can resist the encroachment of the Government into the practice of medicine.

The financial aspects of the practice of medicine assume increasing importance. It is extremely important that we do not kill the goose that lays the golden egg. Under no circumstances should there be double billing, and every effort should be made to help the old folks fill out their forms. We should render sympathy and understanding toward their financial problems and do everything in our power to keep them content. A satisfied patient will help you resist the encroachment of the Government.

Committee participation is all important. It is of the utmost importance that we willingly serve on the various utilization review committees and any other committee either in the hospital or in the community. We must do all we can to make the present system work and must go out of our way to assist when called upon. The planning committees are of extreme importance. It is important that we select wise and knowledgeable consumers for these committees and take an active part in determining their composition.

The practice of medicine is at the cross-roads: how well we supervise and police ourselves may determine how well we will survive!

A practical suggestion: It is urged that the committees on medical legislation on both county and state levels be arranged so that one member of the committee be named to follow one individual law and its changes. Once knowledgeable physicians are located and placed on these committees, an effort should be made to keep them in this position until someone can be broken in to take over their duties.

ROBERT S. PRESSMAN, M.D.
Philadelphia



Someone you know needs



When it's more than a bad cold



your patient can feel better
while he's getting better

Achrocidin[®]

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN[®] Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and

may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



*Address
of the
President*

JOHN H.

HARRIS, SR., M.D.



Presentation before the House of Delegates at the 119th Annual Session of the Pennsylvania Medical Society, Pittsburgh Hilton Hotel, Thursday, September 26, 1968

As others before me have done, I want to express my thanks to the House of Delegates for giving me the high honor of serving as your 118th President. To have served as president of the Pennsylvania Medical Society is the crowning achievement of my career in organized medicine. This career has extended over forty-four years. There have been times when I did not agree with the leaders of organized medicine. Nevertheless, I have always been an organization man and am a firm believer that all physicians should become members of our Society. I would be remiss if I did not again express my thanks to the Dauphin County Medical Society for submitting my name in nomination to this House.

The closer one works with the staff of our Society, the more an officer comes to appreciate the courteous and efficient staff that has been assembled by our Executive Director. Living in Harrisburg, I have visited the office with great frequency and observed the smooth operation of the forty-some people effectively conducting the business of our Society. To them I express my thanks and appreciation for their cooperation.

To the many physicians who devoted their time to the work of our Society, much credit is due. With few exceptions, every physician readily accepted appointments to councils, commissions, and committees when asked. These men and women devote untold hours developing programs and activities so that our Society can achieve its purpose as defined in our constitution. To these people I express my thanks.

Particular credit should go to the Board of Trustees. I think this is the hardest working group in our organization.

As I re-read my address of one year ago, I note that all my suggestions have been given serious consideration and some have been put into operation. I will not go into detail in this regard. Throughout the year the commissions and committees have developed many ideas for the improvement of our Society's operation. These will be presented for your consideration. One of the most important changes for your consideration is the one dealing with medical education.

It is my opinion that the president of the Society deserves

little, if any, credit for any accomplishments which may have developed during his term of office. The Society is so complex that any achievement is due to the combined efforts of many people. The Society has accomplished a number of noteworthy things during the past year.

(1) We have worked with the Department of Welfare to get Title XIX physicians' bills for hospital patients processed by Blue Shield.

(2) We assisted in developing a staff organization for the Susquehanna Valley Regional Medical Program.

(3) We have maintained close liaison with the Governor's office and the Department of Welfare.

(4) We have been able to secure several appointments to the Board of Medical Education and Licensure.

(5) We have taken important steps toward better relationships with the Deans of our medical schools.

(6) We opposed the inclusion of chiropractors' fees in Title XIX.

(7) We were instrumental in having the office of coroner removed from the state constitution.

These are just a few of the many activities of the past year. It is my opinion that many changes are confronting the delivery of health service to the people. Some of these changes will be difficult to accept by many of our members. I will mention only a few areas where long-standing basic principles of our organization are being questioned.

(a) Is fee-for-service the best way to provide health service in this day and age?

(b) Why are so many well-trained physicians leaving the fee-for-service area and accepting salaried positions in the many fields providing health service?

(c) Is freedom of choice of physicians essential to good medical care?

(d) Is solo practice the best way to provide health services? There are numerous studies which clearly question solo practice.

(e) Is militant opposition by some members of our Society to proposed socio-economic changes in the best interest of organized medicine?

(f) Should we refuse to follow such knowledgeable leaders as our own Jim Appel, Dr. Hudson, and the now president of the A.M.A., Dwight Wilbur?

I think it is imperative that the A.M.A. and all component societies should follow such splendid leadership. Dr. Wilbur's father was a leader of the A.M.A. whose liberalism was rejected, but the years have shown that his recommendations for providing medical care have been accepted.

I think our Society should give serious consideration in at least two areas in which we have taken a negative approach to date. First, there are many types of activities for improvement of health care which the Medical Society could pursue if funds were available. In this day and age the government is the source of funds for many health programs. However, our Society has taken a position of refusing public funds, the only exception being the Susquehanna Valley Regional Medical Program. I think our position on the use of government funds should be reconsidered. Second, we have been reluctant to enter the lists against quackery, specifically the chiropractors. It was recently reported that one dollar out of every fifteen spent on health care goes to quack remedies. H. Doyle Taylor, Director of the A.M.A. Department of Investigation, said

that the cost of quackery far exceeds the entire cost of medical education and also the cost of all medical research in this country. I think the Society should take an active part in alerting the public against quackery. I quote the phrase of the paragraph of our constitution defining the purpose of the Pennsylvania Medical Society "and to enlighten and direct public opinion in regard to health and hygiene."

I hope all of you have read Dr. Wilbur's address to the A.M.A. House of Delegates. It is a forward-looking presentation.

At this point I will openly quote from a speech by Donald A. Nickerson, M.D., retiring president of the Massachusetts Medical Society given on May 22nd, of this year. I do this because it delineates my thinking of the problems confronting organized medicine.

"I am concerned . . . that we had not earlier reviewed critically our reason for being, to determine whether or not we are in reality fulfilling our obligations to our patients, our communities, our state, our country, and our profession. . . . A re-evaluation of our objectives with emphasis on and dedication to our stated purposes is essential.

"We must dedicate ourselves to the unselfish providing of high quality medical care to all persons, everywhere. We must develop a social consciousness, aware of our responsibilities as physicians and citizens.

"We must plan ahead and originate methods of providing medical care to all persons consistent with economic and social change, and consistent with high standards of medical practice.

"We must work for increased production of competently trained physicians and paramedical personnel.

"We must seek out ways and means to provide medical care in an economic environment that do not sacrifice quality for quantity . . .

"We must work for and fight for the right to practice in an economic-political climate where personal judgment is not restricted, where the care of the patient remains under the direction of the physician, and where the economic awards are just and equitable . . .

" . . . and we must advise, guide, and lead in all programs designed to extend the providing of medical

care. In this endeavor, we are not alone. Our destiny can be shaped by others. It is our responsibility to lead.

"We must once and for all time avoid frantic rear guard action to postpone that which cannot be postponed.

"We must stop wasting time shoring up structures that are obsolete. Instead we must become constructively militant, calmly aggressive, knowledgeably progressive, and aware always of our limitations, and aware always that as humans, we are like our patients—we have their faults, their joys, their sorrows . . .

"We stand on no pedestal and we sit on the right of no throne.

"As physicians we must never forget that we are in a position to provide compassionate care to persons in need This is our calling, we serve. We are not to be served. Without compassion, humility and love, we are nothing but craftsmen.

"We must demonstrate, as we have never demonstrated, that we can plan ahead to provide comprehensive and complete medical services for all persons.

"The time has come for the medical profession, as represented by organized medicine, to assume the leadership, enlightened and knowledgeable, in the providing of medical care."

This has been an interesting and busy year for me. As problems in the socio-economic field become greater there is a greater demand upon the time of your officers. Fortunately, I have been able to delegate some of this work to Dr. Farrar, Dr. McClenahan, and the Vice Presidents. I have not traveled as much as some of our presidents have, but such visitations as Mrs. Harris and I made to the counties were very enjoyable.

At this point I agree with Dr. McClenahan when he said that one year as President is enough. Tom McCreary did tell me recently that he would have enjoyed another year in office. The demands of the office are such that I doubt that a solo practitioner with a busy practice could afford to accept the office.

In closing, again I express my appreciation for the opportunity of being the 118th president of this great Medical Society.

Address of the President-elect

**GEORGE E.
FARRAR, JR., M.D.**



Presentation before the House of Delegates at the 119th Annual Session of the Pennsylvania Medical Society, Pittsburgh Hilton Hotel, Thursday, September 26, 1968

The difficulties besetting our nation and our state emphasize the humility with which anyone accepts the presidency of the 12,000 physicians of the Pennsylvania Medical Society. This is an honor I enjoy, an opportunity I cherish and a responsibility I fear. I shall do my best to represent you. I can represent you well only insofar as you members of the House of Delegates define the policies of this society specifically enough so that I can express them to all our members and to the public.

Every one of you delegates must recognize that he or she is a leader of all of Medicine. The privileges of freedom must be earned, please remember, by each generation. You are not only a leader of the 12,000 members of this society, but of the 4,000 licensed physicians in Pennsylvania who are not members of this society or of their county medical societies. What you do here affects all physicians.

What I say here, I say to all physicians.

Change

Change is the very nature of our times. Many have pointed out that change must come—we do not have that choice. The only choice presented to us is how we as a group can participate in a truly democratic fashion in

shaping that change. There is no area of life that is not undergoing drastic reshaping—medicine, economics, philosophy.

Medicine

In my professional lifetime of four decades, I have seen the advent of insulin to control diabetes mellitus, liver to correct pernicious anemia, antibiotics to cure most infections, steroids to minimize inflammation and influence metabolism, virus vaccines to prevent damaging childhood diseases, and more lately the well-tolerated oral contraceptives.

We have moved from viewing the "crisis" in pneumococcal lobar pneumonia to the transplanting of a human heart or a kidney. From the encouragement and the sympathy provided by the practitioner of early years, typified by the Luke Fildes painting of *The Doctor* in which a kindly gentleman sits beside a sick child lying on a chair in a kitchen, we have changed to the technology of a modern operating room. Miracles happen; miracles are expected, and now even demanded. When results are less than desired, malpractice suits are frequent. Your Council on Medical Service is actively seeking better insurance for your protection and your Council on Governmental Relations is active on the legislative front to bring a measure of relief to lawsuit-harried physicians.

Economics

This era has been described by J. K. Galbraith¹ as follows: "The initiative in deciding what is to be produced comes not from the sovereign consumer, who, through the market, issues the instructions that bend the productive mechanism to his ultimate will. Rather, it comes from the great producing organization which reaches forward to control the markets that it is presumed to serve and, beyond, to bend the customer to its needs.

"And technology and associated requirements in capital and time lead even more directly to the regulation of demand by the state. A corporation, contemplating an automobile of revised aspects, must be able to persuade people to buy it. It is equally important that people be able to do so. This is vital where heavy advance commitments of time and money must be made and where the products could as easily come to market in a time of depression as of prosperity. So there must be stabilization of overall demand."

Galbraith's description of today's economics cannot apply to health care. Medical care isn't provided by a giant corporation although distribution of health care must be improved. The providers of care cannot control the markets that they serve because human beings are not robots . . . because good health care is a very personal, intimate thing—an eyeball to eyeball relationship of persons with mutual confidence. Humanity still yearns for the attitude of the physician of the Luke Fildes painting.

Politics

Others, such as E. G. Mesthene,² have described how technology will shape the future: "New technology brings about or inhibits changes in physical nature. . . . A new device merely opens a door; it does not compel one to enter. However, a newly opened door does invite one to enter. . . . Insofar as the new options are chosen and the new possibilities are exploited, older possibilities are displaced and older options are precluded or prior choices are reversed. . . . The role of the heavy plow in the organization of rural society and that of the stirrup in the rise of

feudalism provide fascinating medieval examples of a nearly direct technology-society relationship. . . . To the extent that technological change expands and alters the spectrum of what man can do, it multiplies the choices that society will have to make. These choices will increasingly have to be deliberate social choices, moreover, rather than market reflections of innumerable individual consumer choices and will, therefore, have to be made by political means. The emphasis shifts from allegiance to the known, stable, formulated and familiar, to a posture of expectation of change and readiness to deal with it. The mechanisms, the values, attitudes and procedures called for by a social posture of readiness will be different in kind than those characteristic of a society that sees itself as mature, 'arrived,' and in stable equilibrium."

Health Industry

The topic of the inaugural address of the new president of the American Medical Association provides us with a slogan that emphasizes our responsibilities. Dwight L. Wilbur, M.D.,³ 123rd president of the AMA, chose as his topic *Emphasize Steering Instead of the Brake*. Something new? No! The words are a quotation from his father's address as 76th president of the American Medical Association in 1923. We can guide but we cannot slow up the 50 billion dollar health industry in the United States, an industry that represented 6.1 percent of the gross national product in 1967, employing 5 percent of the labor force of 80 million in this country. Of these 4 million health industry employees, two-thirds are highly trained: 10 percent are physicians; 20 percent are nurses. With 308,630 medical doctors for a total population of approximately 200 million, the ratio is one physician for every 658 persons but the Federal Government—Veterans Administration, Health, Education and Welfare and Defense—employ about 50,000 physicians. Of the 50 billion dollars expended on health care, almost one-third is government expenditure. By 1975 the total health care expenditure is estimated at nearly 94 billion dollars a year.

No wonder there is widespread anxiety regarding availability of high quality health care. When we consider that an average hospital bed in the United States cost \$55 per day in 1967 and can only continue to rise as more highly trained technicians are required to provide the excellent medical care of which we are capable, anxiety over cost is indeed justified. Perhaps our citizens have been led to expect⁴ better health care than they wish to pay for or than the national economy can afford, but who is getting the blame? Not the political orator seeking votes! Furthermore, as Dr. Wilbur observed, "A government that expends more than 14 billion dollars for health care (1967 figure) isn't to be ignored." Likewise, the taxpayer cannot ignore the amount and quality of medical services obtained with this amount of his money. The citizen is dependent on physicians to evaluate the quality and quantity of care through peer review activities of organized medicine.

Steering

"Emphasize steering instead of the brake," Dr. Wilbur said. We can't stop the forces that are in motion but we may be able to guide them to a degree and in a way that is beneficial to our nation and its people. To this end, we *must* experiment to improve the quantity and the quality of health care distributed to our citizens.

The expectations of the public⁴ for the best health care in the world threaten to exceed the number of physicians

and our health facilities. The active cooperative effort of every physician is essential for the survival of the medical profession as we know and love it, for the survival of the system of medical care which has so fruitfully advanced the quality of medical care. With apprehension, Dr. E. A. Stead, of Duke University, noted that the medical profession may fail to meet the needs of the American people in the 1970's as the nursing profession has numerically failed in the 1960's.

There is concern about the cost, availability and quality of medical care in a world of change. The three factors are interrelated, but the one that dare not be delegated to others is quality. To meet that factor, we must organize to aid each other in both formal and informal relationships and to provide effective continuing clinical education for our members, plus some adequate incentive for them to utilize the means of the continuing education offered.

Continuing Medical Education

A State Society Task Force has recommended the creation of a council on education. This was adopted by the Board of Trustees and referred to the House of Delegates as an item in the Report of the Committee on Constitution and By-Laws. It is important that some adequate group be assigned the responsibility for continuing medical education.

I recommend 1) that whatever group is given the responsibility for medical education be assigned the implementation in Pennsylvania of the recommendation of the federal Health Manpower Commission,⁵ to "explore the possibility of periodic relicensing of physicians and other health professionals. Relicensure should be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty."

2) The adoption of an appropriate version of the requirements for a continuing membership in the American Academy of General Practice,⁶ which are briefly: one hundred fifty hours of acceptable post-graduate study every three years, a) of which at least fifty hours shall be in approved programs produced by the Academy or by a medical school or a postgraduate medical school, the publication or presentation of an original scientific paper (up to ten hours), the teaching of medical students or physicians (up to twenty hours), or hospital residency training; b) the remaining hours may be obtained from meetings of county and state societies and the American Medical Association, hospital scientific staff meetings, medical school correspondence courses, preparation and presentation of a scientific medical exhibit (up to ten hours).

This group must be provided with adequate financial and other support to conduct an effective program employing all media of communication. Such major programs require large financial support.

I recommend 1) that this group be authorized to solicit and use a) private or b) government financial support as needed and 2) that this Council be authorized to establish a new corporation when needed to handle such funds. Such actions were approved and defined by the House of Delegates of the American Medical Association⁷ in June 1968. Such steps are essential to establish an efficient program to enable our members in all parts of the state to expand their medical education continually.

Allied Professions

To aid us in providing the health care the American people

are expecting, we must enlist and make effective the help of the allied health professions. *I recommend that the appropriate State Society body study the use of allied health professionals, including their educational qualifications, criteria for certification by the state of Pennsylvania, and their legal responsibility in the provision of health care. Many highly trained but incompletely educated medical corpsmen are being discharged from our armed services. We need this health manpower very badly. The aid of the colleges of Pennsylvania should be sought to qualify these veterans for a specific role on the health team and the criteria for certification of this group by the State Board of Medical Education and Licensure needs attention.*

Splintering

In the organizational area, we must correct the splintering of organized medicine's effort that exists among the medical and surgical specialty societies, the academic and research physicians in our schools and in government service, student activist groups and categorical disease foundations, as important as all of these are. Instead of many voices of special interest, we need a united voice for the total medical profession. The American Medical Association is dependent on the fifty state societies of which Pennsylvania is the third largest. Two recommendations seem appropriate:

I recommend representation of established specialty medical societies in Pennsylvania in this House. Voting delegates should be elected by each specialty society as proposed in Resolution No. 68-11. I request action on this resolution at this meeting for implementation at the first possible meeting of this House. The American Medical Association⁸ is endeavoring to increase the participation of all specialty societies in its meetings.

Further, I repeat the idea advanced last year by John H. Harris, Sr., M.D.⁹ that young physicians be brought into the decision-making structure of this Society. *I recommend that a term of two years be established for delegates from Pennsylvania elected after 1969 to the House of Delegates of the American Medical Association with the privilege of serving three consecutive terms if re-elected.* Further, I urge each county medical society to rotate their delegates to the State Society House in a manner appropriate to their local situation. Our Society needs the support of a greater number of its members. Toward this aim, I have appointed new chairmen and vice-chairmen of three administrative councils because the by-laws terminate Council membership after six consecutive years.

Poverty, Inequality and Conflict

Poverty, inequality and conflict is one of the nation's major problems. A resolution dealing with that issue is before this House. *I recommend the adoption of Resolution 68-8.*

Despite what some of our critics infer, the medical profession is not responsible for poverty or for the poor health of the indigent population. However, the medical profession does have an essential role to play. It is not enough that physicians provide quality health care to the poor, for all too often, poverty and ignorance rob the patient of any lasting hope of good health. That is why, as citizens, medical doctors must actively fight poverty and ignorance wherever they exist.

The medical profession always has offered its services to unfortunate people but more is required of us. Dr. Walsh

McDermott¹⁰ of Cornell Medical College made a study during several years of the Navajo tribes in Arizona which shows clearly that the availability of good health care does very little to improve the health of these people. The poverty, unhygienic living conditions and unhealthy customs must be corrected before good clinical services can be effective. Motivation of the individual usually must commence with education of the leaders of his group. As citizens, physicians must encourage political, social, economic and educational activities for our underprivileged people. We must deal actively with diseases of poverty and diseases of ignorance. We must commit ourselves to develop new and innovative programs that will provide the best possible health care for all persons in Pennsylvania. This is our obligation. We cannot shirk it. Much greater attention to the addictive disorders is required of us. In this latter area, the Commission on Mental Health, which has absorbed the Commission on Alcohol and Drug Addiction, will be seeking your cooperation.

In this decade, remember that 70 percent of our citizens live in cities which cover only 1.5 percent of our livable land area. Terry Sanford,¹¹ the former Governor of North Carolina, has been urging that government be taken where the people are. So also must the medical profession devise ways and means to take quality health care in sufficient quantity and in a form they will accept to where the people are. Resolution No. 68-12 proposes a private enterprise effort. *I recommend the adoption of Resolution 68-12 and its implementation in the form of a volunteer effort in our ghettos comparable to Medico and the USS Hope in underdeveloped countries abroad.*

Citizenship

I hope we can cease to waste time in quarreling with our critics (seldom does one win a fight with city hall!). The physician understands human nature better than any other group of people, or thinks he does. Please use your clinical acumen in public affairs.

Our distinguished Pennsylvania physician, Russell B. Roth of Erie, emphasized to the 2nd Annual AMA Congress on the Socio-Economics of Health Care that *only* the physician can provide health care. By training, by experience, by legal license and by interest, *only* the physician can care for the ill, counsel the well and plan realistically for the health care needs of this nation.

There are some appropriate questions for you to ask yourself. What are the major health needs of your community? What are the priorities? What can your community, your state, your nation afford in the way of additional health services? What facilities and health manpower are already available? How could you be more effective? Without the knowledge and experience of the physician, much planning is well-meaning but rather fuzzy. With this in mind, are you personally acquainted with the assemblyman and the senator who represent you in Harrisburg? Do you know and do you contact the congressman and the senators who represent you in Washington? Have you given your representatives in government the benefit of your knowledge and experience? Your Council on Governmental Relations will be asking many of you to aid specific representatives in this manner. I am depending on you to respond. Unless and until you help your representatives serve all of the people, you must expect votes to go against the best advice of the medical profession. Dr. James L. Dennis, of the University of Oklahoma, said it very

well: "The best way to preserve the rights of physicians is to meet the health needs of the people." To say this another way, I quote Dr. Karl Beyer at the American Therapeutic Society last spring meeting. "Credibility is derived from public accountability rather than from past performance."

Planning

Where and how do we start? Continue to provide in your community the public service which is a part of your professional responsibility, as you formerly did in free clinics and on charity hospital wards, but provide this public professional service with even more vigor and devotion as your knowledge and experience enlarge. Investigate the status of health planning for your Regional Medical Program (PL 89-239) and for the Comprehensive Health Planning (PL 89-749) in your area. Don't wait to be invited; health is the responsibility of Medicine!

I hope that each county medical society will become involved in the Regional Medical Program and the Comprehensive Health Planning activities in their communities so that they may offer cooperation and technical medical aid in developing and implementing sound plans to improve the public health.

Specifically, I recommend that each county medical society be requested to provide their District Councilor with an annual report on such activities.

The Pennsylvania Medical Society is fortunate in having responsibility for the Susquehanna Valley Regional Medical Program in cooperation with the developing medical school at Hershey. This provides daily contact with the findings and problems of this program.

The American Medical Association has appointed an Advisory Committee on Health Care of the American People composed of ten distinguished laymen to aid in evaluating the social and economic aspects of health care in our civilization. This committee consists of respected representatives of business, education, religion, law, government, womens organizations, labor, minority groups, publishing and other social and professional elements. With the radical changes of recent years and the continuing adjustments anticipated, such a resource seems like essential social insurance to the medical profession. The AMA has requested each component state and each large county society to appoint a similar committee to assess the situation in its area.

I recommend that the Pennsylvania Medical Society authorize the President annually to appoint such a committee of seven prominent laymen, subject to approval by the Board of Trustees, and I recommend budget authorization for two half-day meetings of the Committee during 1969.

Drugs

Everyone would like to have cheaper health care, including cheaper drugs. Congressional hearings and proposed legislation have made a whipping boy, second only to the medical profession, of our creative pharmaceutical industry.

In 1967, 3.5 billion dollars was paid for prescription drugs at retail.¹² Less than half of that went to the manufacturers. If this item in the nearly 50 billion dollar health care bill were cut in half, the cost of health care would decline by a mere four percent.

For most practicing physicians, involvement in active clinical research is no longer feasible, at least for a majority

of therapeutic agents. The rigid, double-blind protocols required by regulations of the Food and Drug Administration are difficult to adjust to the great variation in individual private patients. The requirement of "informed consent"¹³ in all research programs often is not appropriate in private practice because a natural fear of malpractice actions cannot be ignored.

A resolution, No. 68-22, requesting the Food and Drug Administration to be more sensitive to the problems inherent in the care of sick people is before this House. *I recommend the adoption of Resolution 68-22, "New Uses for Old Drugs."*

Research

You are not reduced to being a technician carrying out the diagnosis and treatment of illness according to the standards of your colleagues as enunciated by your government. Medicine is an investigative science. Careful observation and interpretation of the experiments of nature which come to your attention daily is the way of life of the physician. You can study and compare methods of providing health care as well as study the natural history of disease. How can you measure the quality of health care in the hospital, in the office, in the nursing home?

Here you are dealing "eyeball to eyeball" with the health needs of people. Let us never get separated from people.

Human Dignity

You need not move to a ghetto to show your total concern as a physician and as a person. Respect for human dignity is not a matter of geography.

In your total obligation to God's family of man, you can start in your own home, in your own neighborhood, in your own office, in your own hospital.

The student nurse who is trying to help you needs to be shown that you recognize her effort and appreciate her contribution to the care of the patient. . . . The patient needs to be aware of your concern for the total person. . . . The neighbor deserves to see more than the symbols of your affluence.

Hippocrates said it: "Where there is love for man, there also is love for the art."

REFERENCES

1. Galbraith, J. K.: *The New Industrial State*. Houghton Mifflin, Boston, 1967, pp. 427, pp. 6 & 5.
2. Mesthene, E. G.: *How Technology Will Shape the Future*. Science 161: 135-143 July 12, 1968.
3. Wilbur, D. L.: Emphasize Steering Instead of the Brake, JAMA 205: 89-91 July 8, 1968.
4. Ways, M.: The Dynamite in Rising Expectations. Fortune 77: 133 May 1968.
5. Report of the National Advisory Commission on Health Manpower. 1, p. 93, November 1967, U. S. Government Printing Office, see pp. 42.
6. Continuation Study Requirements, Commission on Education, American Academy of General Practice. GP 35: 173 January 1967.
7. Report A, Council on Medical Service, adopted as amended, House of Delegates, AMA, June 1968.
8. Report of the Ad Hoc Committee to Study the Modus Operandi of the Scientific Sections to the House of Delegates, AMA, June 1968.
9. Harris, J. H., Sr.: Address of the President-Elect. PENNSYLVANIA MEDICINE 70: 95 November 1967.
10. McDermott, W.: The Clinician in an Overly-Traditional Society: A Technological Misfit. Lecture, American College of Physicians, April 1, 1968, Boston.
11. Sanford, T.: *Storm Over the States*. McGraw-Hill, 1967, New York, pp. 218.
12. Zalaznick, S.: Bitter Pills for the Drug Makers. Fortune. 78:82 July 1968.
13. Minchew, B. H. & Gallogly, C.: Informed Consent. FDA Papers 1: 8-11 October 1967.

Q. How much does the **anticoptive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticoptive hematinic is **PERITINIC®**
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate).....	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron).....	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C.....	200 mg
Niacinamide.....	30 mg
Folic Acid.....	0.05 mg
Pantothenic Acid.....	15 mg

Bottles of 60



anticoptive, *adj.* (*anti* opposed to + *costive* causing constipation.)
Against constipation. Now isn't that a good idea in an iron-containing hematinic?



LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

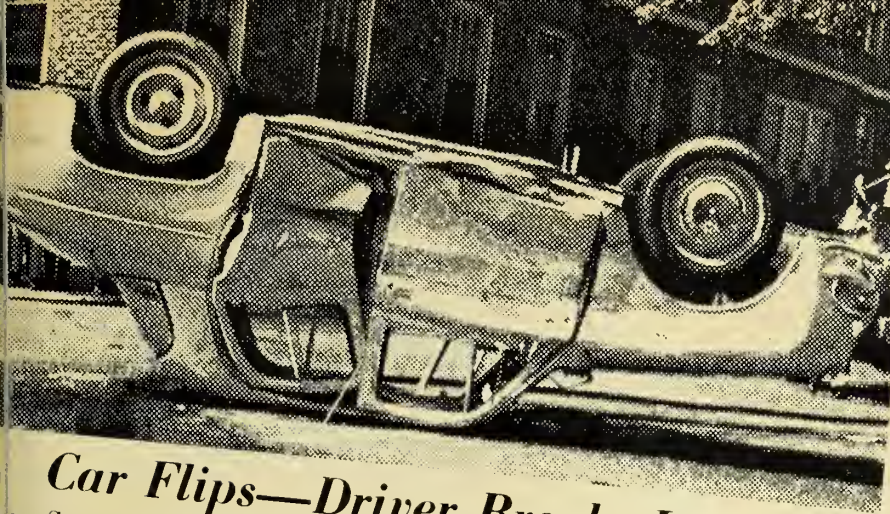
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet dis-

integration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





board h
state
issue, a
tember th
fications'
ton dicta
Althoug
made Mol
down by a
ter shar'
flat obje
was pass
Board
McCred
tion" s'
elimir
the st.
The c
ment ca'
limit re
mile li
"cut-of
public
dren
priv
be b
or th
schoo
The
so so
rather
hurs

Car Flips—Driver Breaks Leg

is, Sept. 7. John P. Jones of
no incurred a broken leg today
driving failed
Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its top
Hasn't he been driving for years?

STAFF PHOTO

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic $\frac{1}{4}$ grain sedative dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: Phenobarbital ($\frac{1}{4}$ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin ($2\frac{1}{2}$ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, $\frac{1}{4}$ gr. (No. 2), $\frac{1}{2}$ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 **A-H-ROBINS**



a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor).....	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B ₁₂ activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.).....	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate).....	110 mg.
Ascorbic Acid (Vitamin C).....	75 mg.
Folic Acid.....	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B₁₂ therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B₁₂ (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potential of absorption of physiological doses of vitamin B₁₂. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B₁₂, may be necessary. No single regimen fits all cases, and the status of the patient observed over follow-up is the final criterion for adequacy of therapy. Periodic



You can treat combined
deficiencies with

Trinsicon[®]

—the multifactor hematinic



Vitamin B₁₂ plus intrinsic factor (15 mcg. B₁₂ activity)—helps provide adequate levels of this Important vitamin.



Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.



Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps Iron absorption.



Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Usage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon[®] (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500.

[032568]

Additional information
available to physicians
upon request.

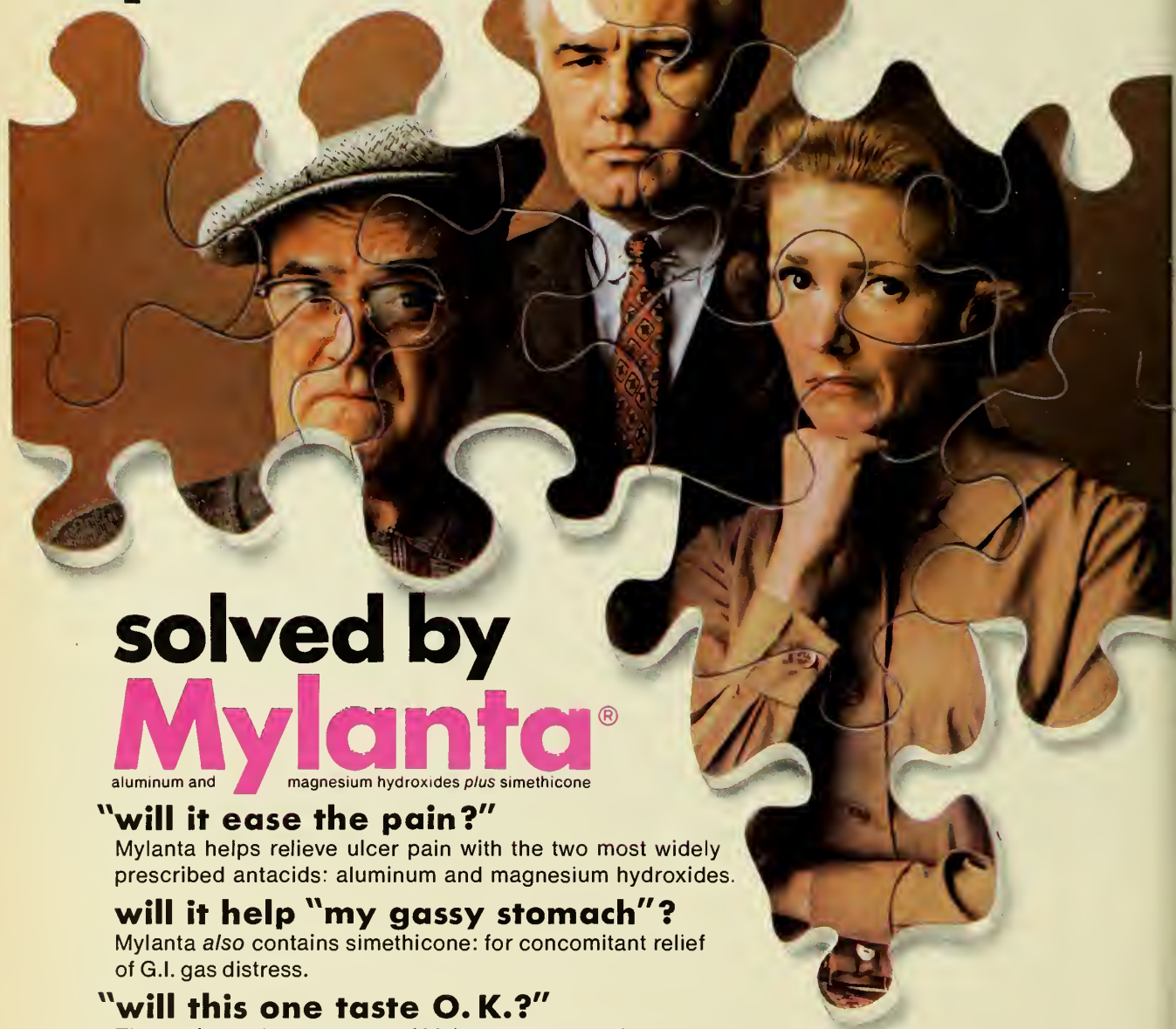
Eli Lilly and Company,
Indianapolis, Indiana 46206.

801668

Lilly

In
peptic
ulcer:

the antacid puzzle



solved by **Mylanta**[®]

aluminum and magnesium hydroxides plus simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta also contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients — after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

PMS

OFFICIALLY
ENDORSED

DISABILITY INSURANCE PROGRAMS

ACCIDENT AND HEALTH PROTECTION

Indemnities up to \$250.00 per week. Long term sickness and lifetime accident protections available. Daily hospital benefits and surgical protection available for both members and dependents. Selection of waiting periods. Conversion plans available at age 70.

MAJOR HOSPITAL EXPENSE PROTECTION

\$7,500 Maximum Benefits after \$500 deductible for both members and dependents.
This protection may be retained *for life!*

HIGH LIMIT ACCIDENTAL DEATH, DISMEMBERMENT AND PERMANENT TOTAL DISABILITY

Maximum limit \$150,000 members; \$75,000 wife of member. New low cost of \$.85 per thousand per year. Full principal sum paid for permanent and total disability from bodily injury.

• BERTHOLON-ROWLAND AGENCIES •

WESTERN PENNSYLVANIA

Dexter Bertholon-Rowland, Inc.

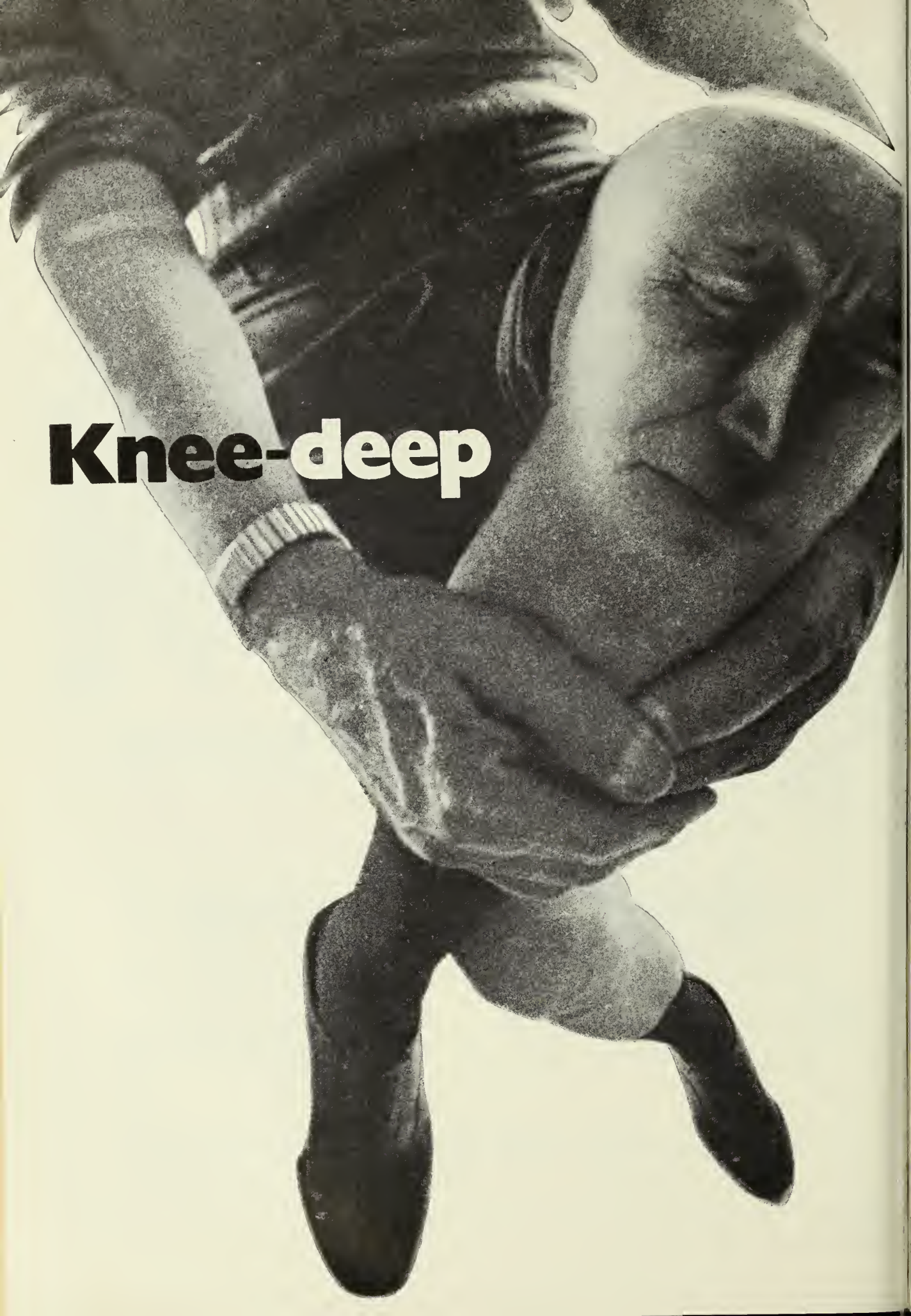
1518 Frick Building, Pittsburgh, Pa. 15219
471-9552
(area code 412)

EASTERN PENNSYLVANIA

Bertholon-Rowland, Inc.

Public Ledger Bldg., Philadelphia, Pa. 19106
WAlnut 5-7045
(area code 215)

★ THE MAN WHO PLANS AHEAD INSURES WHILE HE IS INSURABLE ★



Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil[®]
oxyphenbutazone

Tandearil, oxyphenbutazone:
for brief summary see next page.

Geigy



Tandearil[®]

oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discon-

tinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

 Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardley, New York 10502

PENNSYLVANIA
MEDICAL
SOCIETY

OCTOBER
27-28-29
1968

COMMITTEE
ON
CONVENTION
PROGRAMS

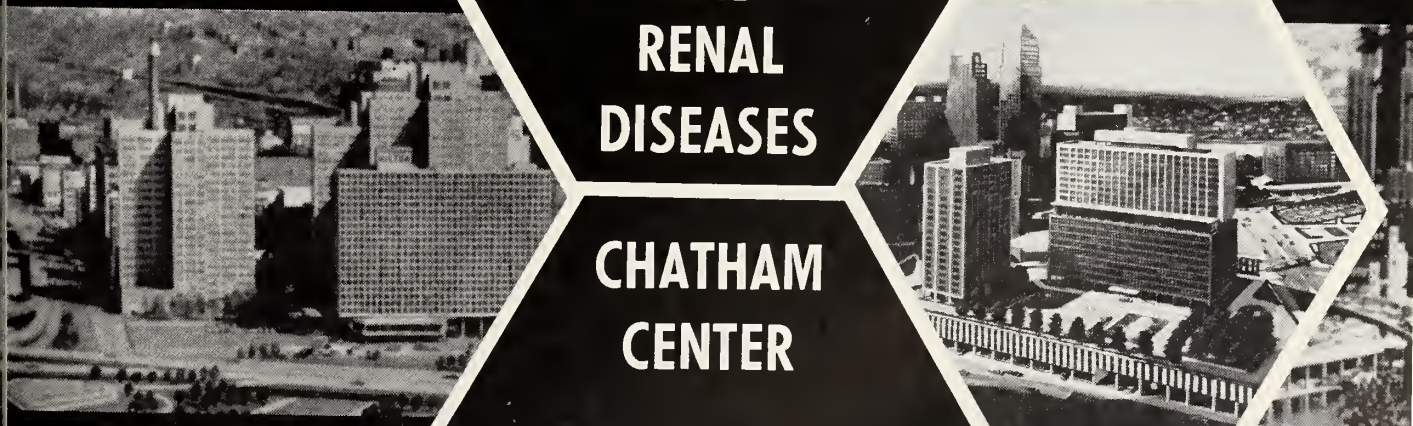
1968 *Scientific Seminars*

ELECTROLYTE
METABOLISM
AND
RENAL
DISEASES

CHATHAM
CENTER

PITTSBURGH

1968
TECHNICAL
EXHIBITS



seminars for physicians

Theme: "ELECTROLYTE METABOLISM AND RENAL DISEASES"

Sunday, October 27, 1968

MORNING SESSION: WATER AND SODIUM IN HEALTH AND ILLNESS

Session Chairman: James A. Collins, Jr., M.D., Chairman, Committee on Convention Program

8:30 a.m. **BASIC CONSIDERATIONS**

Martin Goldberg, M.D., Chief, Renal-Electrolyte Section, Dept. of Med., University of Pennsylvania School of Medicine

9:00 a.m. **ACIDOSIS AND ALKALOSIS**

J. Bernard L. Gee, M.D., University of Pittsburgh School of Medicine

9:25 a.m. **THE LOW SODIUM SYNDROMES: IDENTIFICATION AND TREATMENT**

T. S. Danowski, M.D., Professor of Medicine, University of Pittsburgh School of Medicine

9:45 a.m. **PROPER THERAPY OF EDEMA OF VARIOUS ORIGINS**

John H. Moyer, III, M.D., Professor and Chairman, Department of Medicine, Hahnemann Medical College and Hospital

(10:15 A.M. to 10:30 A.M.—COFFEE BREAK)

10:30 a.m. **PANEL: CONGESTIVE HEART FAILURE**

Moderator: Martin Goldberg, M.D.
Participants: J. Bernard L. Gee, M.D.
T. S. Danowski, M.D.
John H. Moyer, III, M.D.

LUNCHEON SESSIONS:

12:15 p.m. to 1:45 p.m.

I. **HYPERTENSION AND RENAL DISEASE**

Chairman: John H. Moyer, III, M.D.

Participants: Donald G. Vidt, M.D., Staff Member, Dept. of Hypertension & Renal Disease, Cleveland Clinic Foundation

Michael Simenhoff, M.D., Assistant Professor of Medicine, Clinical Research Center, Jefferson Medical College Hospital

II. **ELECTROLYTE COMPLICATIONS OF DIURETIC THERAPY**

Chairman: Jerome Chamovitz, M.D., Sewickley, Member, Committee on Convention Program

Participants: Sheldon Adler, M.D., Montefiore Hospital, Pittsburgh

David P. Lauler, M.D., Director, Endocrine-Metabolic Unit, Peter Bent Brigham Hospital, Boston

AFTERNOON SESSION: POTASSIUM OUTSIDE AND INSIDE CELLS

Session Chairman: T. S. Danowski, M.D., Member, Committee on Convention Program

2:00 p.m. **BASIC CONSIDERATIONS**

Martin Goldberg, M.D.

2:20 p.m. **THE ALDOSTERONE PROBLEM**

David P. Lauler, M.D., Director, Endocrine-Metabolic Unit, Peter Bent Brigham Hospital, Boston

2:50 p.m. **CIRCULATION AND FLUIDS IN SURGICAL PATIENTS**

Henry T. Randall, M.D., Rhode Island Hospital, Providence, Rhode Island

(3:15 P.M. TO 3:45 P.M.—

INTERMISSION TO VIEW EXHIBITS)

3:45 p.m. **PANEL: DILEMMAS IN WATER, ELECTROLYTE AND COLLOID THERAPY**

Moderator: T. S. Danowski, M.D.
Participants: Martin Goldberg, M.D.
David P. Lauler, M.D.
Henry T. Randall, M.D.
Jacques L. Sherman, Jr., M.D., Medical Director, Maimonides Medical Center, Brooklyn, N.Y.

Monday, October 28, 1968

MORNING SESSION: RENAL DISORDERS--NEPHRITIS AND NEPHROSIS

Session Chairman: Robert L. Evans, M.D., Member, Committee on Convention Program

9:00 a.m. **CURRENT CONCEPTS OF RENAL FUNCTION (INCLUDING CLINICAL AGING, ACUTE INJURY)**

H. Victor Murdaugh, Jr., M.D., Associate Professor of Medicine, University of Pittsburgh School of Medicine

9:20 a.m. **THE MANAGEMENT OF THE NEPHRITIDES**

Frank M. Mateer, M.D., Director of Medical Education & Research, The Western Pennsylvania Hospital, Pittsburgh

9:50 a.m. **THE NEPHROTIC STATE**

Charles D. Swartz, M.D., Assistant Pro-

fessor of Medicine Hahnemann Medical College and Hospital

(10:15 A.M. TO 10:45 A.M. INTERMISSION TO VIEW EXHIBITS)

10:45 a.m. **PANEL: THE REVERSIBLE RENAL DISORDERS**

Moderator: H. Victor Murdaugh, Jr., M.D.

Participants: Frank M. Mateer, M.D.
Charles D. Swartz, M.D.
Christina Comty, M.D., Assistant Professor of Medicine, Univ. of Pgh. School of Medicine

LUNCHEON SESSIONS:

12:15 p.m. to 1:45 p.m.

I. DIAGNOSTIC LABORATORY AND X-RAY STUDIES FOR RENAL DISEASE

Chairman: Jerome Chamovitz, M.D.

Participants: The Value & Pitfalls of Laboratory Studies in Kidney Disease

Donald G. Vidt, M.D., Cleveland Clinic

The Radioisotopic Techniques in Renal Disease & Diagnoses

David Beiler, M.D., Geisinger Medical Center

II. DIALYSIS IN A COMMUNITY HOSPITAL

Chairman and Moderator: Albert N. Brest, M.D., Department of Medicine, Hahnemann

Participants: Frederick Brown, M.D., Section of Renology, Geisinger Medical Center, Danville

Albert R. Pechan, D.D.S., Chairman, Committee on Health and Welfare, Senate of Pa.

AFTERNOON SESSION: MANAGEMENT OF URINARY INFECTIONS AND OF UREMIA

Session Chairman: John H. Killough, M.D., Member, Committee on Convention Program

2:00 p.m. **RISKS OF URINARY TRACT INSTRUMENTATION**

Calvin M. Kunin, M.D., Professor of Preventive and Internal Medicine, University of Virginia School of Medicine

2:30 p.m. **PYELONEPHRITIS—A DIAGNOSTIC AND THERAPEUTIC PROBLEM**

James E. Clark, M.D., Chief of Medicine, Crozier-Chester Medical Center, Chester

3:00 p.m. **THE NATURAL HISTORY OF CHRONIC RENAL FAILURE**

Donald E. Oken, M.D., Associate Di-

rector, Cardiorenal Section, Peter Bent Brigham Hospital

(3:30 P.M. TO 4:00 P.M.—INTERMISSION TO VIEW EXHIBITS)

4:00 p.m. **PANEL: CHRONIC RENAL DISEASE—THE ROLE OF DIALYSIS AND TRANSPLANTATION**

Moderator: James E. Clark, M.D.

Participants: Donald E. Oken, M.D.
Theodore T. Tsaltas, M.D., Professor of Pathology, Jefferson Medical College
Donald G. Vidt, M.D.

seminar on renal diseases for nurses, allied professionals

(Co-Sponsored by the Pennsylvania Nurses Association)

Monday, October 28, 1968

MORNING SESSION:

Session Chairman: John H. Killough, M.D., Member, Committee on Convention Program

9:00 a.m. **RISKS OF URINARY TRACT INSTRUMENTATION**

Calvin M. Kunin, M.D., Prof. of Prev. and Internal Med., Univ. of Virginia School of Medicine

9:30 a.m. **MANAGEMENT OF BACTEREMIC SHOCK**

Lewis C. Mills, M.D., Professor of Endocrinology, Dept. of Medicine, Hahnemann Medical College & Hospital

10:00 a.m. **WHAT IS PYELONEPHRITIS?**

James E. Clark, M.D., Chief of Medicine, Crozier-Chester Medical Center, Chester

(10:30 A.M. TO 10:50 A.M.—
INTERMISSION TO VIEW EXHIBITS)

10:50 a.m. **PANEL: URINARY TRACT INFECTION**

Moderator: Lewis C. Mills, M.D.

Participants: Calvin M. Kunin, M.D.
James E. Clark, M.D.

(12:00 NOON TO 1:30 P.M.—
INTERMISSION FOR LUNCH)

AFTERNOON SESSION:

Session Chairman: Robert L. Evans, M.D., Member, Committee on Convention Program

1:30 p.m. **THE VALUE OF THE CENTRAL VENOUS PRESSURE MONITORING DETERMINATION**

Frederick Weiss, M.D., Dept. of Med., Univ. of Pgh.

1:50 p.m. **USE AND ABUSE OF DIURETICS**

Charles D. Swartz, M.D., Hahnemann Medical College

(2:20 P.M. TO 2:35 P.M.—
INTERMISSION TO VIEW EXHIBITS)

2:35 p.m. **SYMPOSIUM: THE ARTIFICIAL KIDNEY**

Moderator: Albert N. Brest, M.D., Dept. of Med., Hahnemann
Introduction—Moderator

2:40 p.m. **WHO NEEDS AN ARTIFICIAL KIDNEY UNIT—WHAT HOSPITAL?**

Frederick Brown, M.D., Geisinger Medical Center, Danville

2:55 p.m. **THE SELECTION OF PATIENTS**

Christina Comty, M.D., Asst. Professor of Medicine, Univ. of Pgh. School of Med.

3:10 p.m. **THE ROLE OF THE TECHNICIAN**

Richard L. Hessert, Downstate Medical Center, Brooklyn, N.Y.

3:25 p.m. **SPECIAL NURSING PROBLEMS**

Murial Shaffer, R.N., Artificial Kidney Unit, Geisinger Medical Center

3:45 p.m. **DISCUSSION (under direction of afternoon moderator, including all participants)**

evening programs

Sunday, October 27, 1968

GROUP PRACTICE

(For all Physicians including Residents, Interns, Students)

Session Chairman: George E. Farrar, Jr., M.D., President, Pennsylvania Medical Society

8:00 p.m. **GENERAL CONCEPTS OF GROUP PRACTICE**

Richard Magraw, M.D., Department of Health, Education and Welfare, Washington, D.C. (Acting Deputy Assistant Secretary for Health Manpower)

8:45 p.m. **MULTISPECIALTY GROUP PRACTICE—WHAT MAKES A GOOD GROUP?**

Walter I. Buchert, M.D., Director, Geisinger Medical Center

9:10 p.m. **THE SINGLE SPECIALTY GROUP**

Allen W. Cowley, M.D., Cowley Associates, Harrisburg

9:30 p.m. **DISCUSSION**

Monday, October 28, 1968

THE STATUS OF ORGAN TRANSPLANTATION

(co-sponsored by the PMS Committee on Medicine and Religion)

Session Chairman: John H. Moyer, III, M.D., Member, Committee on Convention Program

Moderator: Ivan D. Baronofsky, M.D., Professor and Chairman, Department of Surgery, Hahnemann Medical College and Hospital

Panelists: Jacques L. Sherman, Jr., M.D., Medical Director, Maimonides Medical Center, Brooklyn, N.Y.

Seward Hiltner, Ph.D., Professor of Theology and Personality, Princeton Theological Seminary, Princeton, N.J.

Holbrook M. Bunting, Jr., Attorney, Pepper, Hamilton & Scheetz, Philadelphia

Donald E. Oken, M.D., Associate Director, Cardiorenal Section, Peter Bent Brigham Hospital, Boston

Paul B. McCleave, LL.D., Director, Department of Medicine and Religion, AMA, Chicago

specialty society meetings

Pennsylvania Allergy Association

Tuesday, October 29, 1968

RECENT ADVANCES IN ASTHMA

9:00 a.m. to

Ballroom No. 6

12:30 p.m. **Presiding:** Martin L. Lee, M.D., President-Elect, Pennsylvania Allergy Association

9:00 a.m. **INTRODUCTION**

Gilbert A. Friday, M.D., Program Chairman, Clinical Assistant Professor of Pediatrics, University of Pittsburgh School of Medicine

9:05 a.m. **IMMUNO-PATHOLOGY**

PHILIP FIREMAN, M.D., Director of Allergy and Immunology, Children's Hospital of Pittsburgh, Assistant Professor of Pediatrics, University of Pittsburgh School of Medicine

9:30 a.m. **PATHO-PHYSIOLOGY**

J. Bernard L. Gee, M.D., Associate Professor of Medicine, University of Pittsburgh School of Medicine

10:00 a.m. **PSYCHO-PATHOLOGY**

John B. Reinhart, M.D., Associate Professor of Psychiatry and Pediatrics, University of Pittsburgh School of Medicine

(10:30 A.M. TO 10:45 A.M.—

INTERMISSION TO VISIT EXHIBITS

Coffee will be served in the exhibit area)

10:45 a.m. **RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF ASTHMA**

Carl R. Arbesman, M.D., Associate Clinical Professor of Immunology and Bacteriology, State University of New York at Buffalo

11:30 a.m. **PANEL DISCUSSION—COMPREHENSIVE APPROACH TO THE ASTHMATIC PATIENT**

Case Presentation: Carlton R. Palm, M.D., Fellow in Pediatric Allergy, Children's Hospital of Pittsburgh

Moderator: Leonard S. Girsh, M.D.

Participants: Above speakers plus Florence Erickson, R.N., Ph.D., Professor and Chairman, Department of Pediatric Nursing, University of Pittsburgh

Lois Myers, ACSW, Psychiatric Social Worker, Children's Hospital of Pittsburgh

Dorothy Hoskins, R.N., B.S., Public Health Coordinator, Children's Hospital of Pittsburgh

8:00 p.m. ***In Vitro* METHODS FOR DEMONSTRATIONS OF REAGINS**

Carl R. Arbesman, M.D., Concordia Club, 4024 O'Hara St., Pittsburgh

Pennsylvania Chapter, American College of Chest Physicians

(Co-Sponsored by the Pennsylvania Thoracic Society)

Tuesday, October 29, 1968

CHEST DISEASES

1:30 p.m. to 4:00 p.m. **SCIENTIFIC PROGRAM** Ballroom No. 5

Presiding: Henry R. Madoff, M.D.

1:30 p.m. **ATYPICAL MICROBACTERIAL INFECTIONS IN CHILDREN**

Edward W. Saitz, M.D., Assistant Professor of Pediatrics, Children's Hospital, Pittsburgh

2:00 p.m. **PANEL DISCUSSION: ETIOLOGY, DIAGNOSIS AND MANAGEMENT OF HEMOPTYSIS**

Moderator: J. J. Kirshner, M.D., Jefferson Medical College
Surgeon: Albert G. Marrangoni, M.D., Mercy Hospital, Pittsburgh

Radiologist: Robert N. Berk, M.D., Univ. of Pittsburgh, School of Medicine

Internist: E. Wayne Marshall, Jr., M.D., Assistant Professor of Medicine, University of Pa.

3:00 p.m. **ANNUAL CHEVALIER JACKSON MEMORIAL LECTURE—THE SKIN COVERING OF THE LUNG**

Sol Katz, M.D., Chief of Medicine, Veterans Administration Hospital, Washington, D.C.

4:00 p.m. **BUSINESS MEETING** Ballroom No. 5
Pennsylvania Chapter, American College of Chest Physicians

Pittsburgh Academy of Dermatology

Tuesday, October 29, 1968

DERMATOLOGY

3:00 p.m. to 4:30 p.m. **SCIENTIFIC PROGRAM** Ballroom No. 3

3:30 p.m. **INTRODUCTIONS**

3:45 p.m. So-Called Collagen Diseases and Elastosis of Skin—Edwin R. Fisher, M.D., Professor

of Pathology, Univ. of Pittsburgh School of Medicine

4:30 p.m. to 7:00 p.m. **BUSINESS MEETING**
Pittsburgh Academy of Dermatology

Pennsylvania Society of Internal Medicine and American College of Physicians

Tuesday, October 29, 1968

INTERNAL MEDICINE

12:00 noon to

1:00 p.m. **LUNCHEON**

Ballroom No. 4

1:15 p.m.

INTRODUCTIONS

Robert S. Pressman, M.D., President,
Pennsylvania Society of Internal
Medicine

William Cooper, M.D., Governor,
American College of Physicians

1:15 p.m. to

Ballroom No. 4

5:00 p.m. **SCIENTIFIC PROGRAM**

ALL ABOUT RENAL BIOPSY

Moderator: William Cooper, M.D.

1:30 p.m. **RENAL BIOPSY—INDICATIONS, TECH-
NIQUES, COMPLICATIONS**

James A. Nicotero, M.D., Chief of
Hemodialysis, Oakland Veterans
Hospital, Pittsburgh

2:00 p.m. **HISTOPATHOLOGY AND ELECTRON MI-
CROSCOPY OF THE RENAL BIOPSY**

Edwin R. Fisher, M.D., Chief of Labora-

tory, Veterans Hospital; Professor
of Pathology, University of Pitts-
burgh School of Medicine

3:00 p.m.

HISTOCOMPATABILITY TYPING

Raymond Mark, M.D., Assistant Pro-
fessor of Pathology, University of
Pittsburgh School of Medicine

(3:30 P.M. TO 4:00 P.M.—

INTERMISSION TO VIEW EXHIBITS)

RESPONSES OF 'SELF' AND FOREIGN RENAL TISSUE

Moderator: Roy L. Titchworth, M.D.,
Program Chairman, PSIM

4:00 p.m. **ANTILYMPHOCYTE SERUM**

Stewart Sell, M.D., Associate Professor
of Pathology, University of Pitts-
burgh School of Medicine

4:30 p.m. **EXPERIENCES WITH IMMUNOSUPPRES-
SIVE THERAPY IN CLINICAL RENAL**

TRANSPLANTATION

Bernard Fisher, M.D., Professor of
Surgery, University of Pittsburgh
School of Medicine

5:00 p.m. to

6:00 p.m.

COUNCIL MEETING

Pennsylvania Society of Internal Med-
icine

Ballroom No. 4

Mid-Atlantic Neurosurgical Society

NEUROSURGERY

Tuesday, October 29, 1968

12:00 noon to

1:00 p.m. **COUNCIL MEETING**

Room 1001

1:00 p.m.

**DISCUSSION OF CASES SUBMITTED TO
PANEL FOR DIAGNOSIS AND MANAGE-
MENT**

1:00 p.m. to

5:00 p.m. **SCIENTIFIC PROGRAM**

Ballroom No. 1

**STUMP THE EXPERTS—A PANEL DISCUS-
SION OF INTERESTING NEUROSURGICAL
CASES**

Moderator: George Gray, M.D.

Panelists: Arthur B. King, M.D.

Stuart Rowe, M.D.

Henry Shenkin, M.D.

James Watts, M.D.

(3:00 P.M. TO 3:30 P.M.—

INTERMISSION TO VIEW EXHIBITS)

Coffee will be served in the exhibit area

3:20 p.m.

SUBMISSION OF CASES FROM FLOOR

5:00 p.m. to

6:00 p.m.

BUSINESS MEETING

Ballroom No. 1

6:00 p.m. to

9:30 p.m.

COCKTAILS AND DINNER

Ballroom No. 2

Pennsylvania Academy of Ophthalmology and Otolaryngology

OPHTHALMOLOGY & OTOLARYNGOLOGY

Tuesday, October 29, 1968

Presiding Officer: Sebastian Arena, M.D., Chairman,
Program Committee

3:30 p.m. to Ballroom No. 2, Chatham Center
5:00 p.m. **SCIENTIFIC PROGRAM**

Topic: **NYSTAGMUS—DIFFERENTIAL DIAGNOSIS, IM-
PLICATIONS AND TREATMENT**

Speakers: David A. Hiles, M.D., Clinical Assistant Pro-

fessor of Ophthalmology, University of
Pittsburgh School of Medicine
Donald B. Kamerer, M.D., Assistant Instruc-
tor, Dept. of Otolaryngology, University
of Pittsburgh School of Medicine
Robert P. Blume, M.D., Clinical Assistant
Instructor, Dept. of Medicine, Division of
Neurology, University of Pittsburgh
School of Medicine

Pennsylvania Orthopaedic Society

ORTHOPAEDICS

Tuesday, October 29, 1968

9:00 a.m. to Ballroom No. 7, Chatham Center
4:00 p.m. **SCIENTIFIC PROGRAM**

MORNING SESSION

Session Chairman: Richard Kaplan, M.D.

9:00 a.m. **DIAPHYSECTOMY FOR HUMERAL CYST**
William B. McNamee, M.D., Philadel-
phia

9:15 a.m. **A REVIEW OF 200 CONSECUTIVE HIP
FRACTURES**
David B. Baird, M.D., Philadelphia
Zachary B. Friedenber, M.D., Phila-
delphia

9:30 a.m. **SURGERY OF THE RHEUMATOID KNEE**
John Sbarbaro, M.D., Philadelphia

9:45 a.m. **ANTERIOR CERVICAL SPINE FUSION**
Irvin Stein, M.D., Philadelphia
Martin L. Beller, M.D., Philadelphia

10:00 a.m. **ANTERIOR CERVICAL FUSION, USING
THE HALL AIR DRILL**
John Blakley, M.D., Pittsburgh
Robert F. Botkin, M.D., Pittsburgh
David E. Foss, M.D., Pittsburgh

10:15 a.m. **COMPOSITE BONE GRAFTING IN RE-
PLACEMENT OF GROWING BONES**
Benedict F. Magsamen, M.D., Philadel-
phia

(10:30 A.M. TO 11:00 A.M.—

INTERMISSION TO VIEW EXHIBITS)

Coffee will be served in the exhibit area

11:00 a.m. **FUNCTIONAL RESTORATION OF THE
THUMB BY POLLICIZATION OF THE IN-
DEX FINGER**

William J. Mitchell, M.D., Uniontown

11:15 a.m. **SURGICAL AND NON SURGICAL CARE
OF THE STROKE AND SPASTIC PATIENT**

Vernon L. Nickel, M.D., Medical Di-
rector, County of Los Angeles,
Rancho Los Amigos Hospital,
Downey, California

(12 NOON TO 1:30 P.M.—INTERMISSION FOR LUNCH)

AFTERNOON SESSION

Session Chairman: Richard Kaplan, M.D.

1:30 p.m. **RECENT POLICIES IN THE UNITED STATES
DEPARTMENT OF HEALTH, EDUCATION
AND WELFARE**

George Silver, M.D., Deputy Assistant
Secretary for Health and Scientific
Affairs

2:00 p.m. **PANEL: JOINT BIOMECHANICS**

Chairman: Albert B. Ferguson, Jr.,
M.D., Professor of Orthopaedic
Surgery, University of Pittsburgh
School of Medicine

**MECHANICAL STRESS ANALYSIS IN
VARYING POSITIONS OF THE HIP**

Karl Semlak, M.D., Pittsburgh

LUBRICATION OF A HUMAN JOINT

George Bugliarello, M.D., Chairman,
Department of Biotechnology, Car-
negie-Mellon University

**GENERAL AND SPECIFIC OBSERVATIONS
ON JOINT LUBRICATION**

Richard White, M.D., Allentown

**THE EFFECT OF EXCESS FLUID ON THE
HIP JOINT**

Karl Semlak, M.D., Pittsburgh

4:00 p.m. to

5:00 p.m. **BUSINESS MEETING**

Ballroom No. 7

Monday, October 28, 1968

8:00 p.m. **BOARD MEETING**

Room 1001

Pennsylvania Academy of Physical Medicine and Rehabilitation

PHYSICAL MEDICINE & REHABILITATION

Tuesday, October 29, 1968

9:00 a.m. to

Ballroom No. 3

12:00 noon **SCIENTIFIC PROGRAM**

Program Committee Chairman: Max
A. Stoner, M.D., Harrisburg

**THEME: OFFICE MANAGEMENT OF COM-
MON MINOR SHOULDER, KNEE AND
FOOT PROBLEMS**

9:00 a.m.

**EVALUATION AND TREATMENT OF THE
PAINFUL SHOULDER**

Robert Stevens, M.D., Director, Physi-
cal Medicine and Rehabilitation, Wil-
liamsport General Hospital

9:35 a.m.

QUESTIONS AND ANSWERS

9:50 a.m.

**BIOMECHANICS AND TREATMENT OF
THE COMMON KNEE DISORDERS**

Rex Newton, M.D., Physiatrist, Pitts-
burgh

10:25 a.m.

QUESTIONS AND ANSWERS

(10:40 A.M. TO 11:10 A.M.—

INTERMISSION TO VIEW EXHIBITS

Coffee will be served in the exhibit area)

11:10 a.m.

**OFFICE MANAGEMENT OF MINOR FOOT
PROBLEMS**

John McM. Mennell, M.D., Director
Physical Medicine and Rehabilitation,
Philadelphia General Hospital

11:45 a.m.

QUESTIONS AND ANSWERS

12:30 p.m. to

Ballroom No. 3

2:30 p.m. **BUSINESS MEETING & LUNCHEON**

Pittsburgh Proctologic Society

PROCTOLOGY

Tuesday, October 29, 1968

12:00 noon to

Room 1023

1:00 p.m. **LUNCHEON**

1:00 p.m. to

Room 1022

4:00 p.m. **SCIENTIFIC PROGRAM**

**CONSTIPATION IN CHILDREN AND RELATED COMPLI-
CATIONS**

Albert L. Amshel, M.D., Pittsburgh

**THE SURGICAL MANAGEMENT OF RECTAL PROCI-
DENTIA**

Harry E. Bacon, M.D., Philadelphia

PLASTIC RELIEF OF ANAL STENOSIS

Joseph B. Sarner, M.D., Philadelphia

**OBSCURER CAUSE OF ABDOMINAL PAIN: INFARCTED
TAENIA EPIPLOICA**

Burchard E. Winne, M.D., Toledo, Ohio

**OPERATING ROOM STERILITY FOLLOWING COLOREC-
TAL SURGERY**

George F. MacDonald, M.D., Pittsburgh

GUEST SPEAKER

PRIMARY SURGERY FOR ANAL FISTULAE

Jack W. McElwain, M.D., Bethpage, New York

Pennsylvania Psychiatric Society

PSYCHIATRY

Tuesday, October 29, 1968

1:00 p.m. to 4:00 p.m. **SCIENTIFIC PROGRAM**

Co-chairmen, Program Committee: William E. Kelly, M.D. and Homer V. Capparelli, M.D.

1:00 p.m. **ASSASSINATION AND MASS HYSTERIA**

Maurice E. Linden, M.D., Director, Division of Mental Health, Department of Public Health of Philadelphia

1:50 p.m. **PRESENT AND FUTURE DEVELOPMENTS IN DRUG THERAPY OF EMOTIONAL DISORDERS**

Frank J. Ayd, Jr., M.D., Editor, International Drug Therapy Newsletter, Baltimore, Md.

Ballroom No. 6

(2:40 P.M. TO 3:10 P.M.—
INTERMISSION TO VIEW EXHIBITS)
Coffee will be served in the exhibit area

3:10 p.m. **THE PSYCHODYNAMICS OF PHYSICIANHOOD**

Ralph N. Zabarenko, M.D., Clinical Assistant Professor of Psychiatry, School of Medicine, University of Pittsburgh

4:30 p.m. to 6:00 p.m. **BUSINESS MEETING**

Pennsylvania Psychiatric Society

Monday, October 28, 1968

8:00 p.m. to 11:00 p.m. **COUNCIL MEETING**

Pennsylvania Psychiatric Society

Room 1041

Urological Association of Pennsylvania, Inc.

UROLOGY

Sunday, October 27, 1968

6:30 p.m. **BANQUET MEETING**

at "The Edge" Restaurant, Pittsburgh
Guest Speaker: Russell B. Roth, M.D.,
Erie, Pa., Vice Speaker, House of
Delegates, AMA

Pennsylvania Association of Clinical Pathologists

Tuesday, October 29, 1968—COUNCIL MEETING—1:00 p.m.—Room 1041

Pennsylvania Radiological Society

Sunday, October 27, 1968—BOARD OF DIRECTORS—12:30 p.m.—Room 1022

medical alumni activities

The following social events have been planned by medical alumni associations during this session:

TEMPLE—Reception—Sunday, October 27, 6:00 p.m.—
Ballroom #1, Chatham Center.

JEFFERSON—Cocktails and Dinner—Monday, October
28, 6:30 p.m. Duquesne Club.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use cautiously, especially in the first trimester. **Note:** The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.

a stuffy nose
is no
laughing matter

Ornade[®] Trademark

Each capsule contains 8 mg. of Teldrin[®] (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule[®] Capsules

brand of sustained release capsules

each one can
give him all-day
or all-night relief
of nasal congestion



Smith Kline & French Laboratories



Smiles speak louder than words for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.



a product of
LOMA LINDA FOODS
MEDICAL PRODUCTS DIVISION
RIVERSIDE, CALIFORNIA
Mount Vernon, Ohio, U. S. A.



Available in
Concentrated Liquid or Powdered





BENADRYL in '68

choose an experienced candidate—
millions of doses prescribed

Benadryl[®]
(diphenhydramine hydrochloride)



The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals[®], containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

No two women are
quite alike...



and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.



The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968^{1,2} estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy,

migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T³ values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: *Brit. Med. J.* 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: *Brit. Med. J.* 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE

Where "The Pill" Began

G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



**"Breathing's
a snap again,"
he said
gingerly.**

(COMPLIMENTS OF
DIMETAPP)

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

in sinusitis, colds, U.R.I. **Dimetapp® Extentabs®**

(Dimetane® [brompheniramine maleate], 12 mg.;
phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear
breathing on one tablet

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care

to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

Dosage: 1 Extentab morning and evening.

Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A-H-ROBINS



Normal and Abnormal Circulatory Changes in Pregnancy

Part I

What is the incidence of heart disease in pregnancy?

From 1.25 to 3.5 per cent.

What etiologic types of heart disease are commonly encountered?

Rheumatic heart disease is seen in about 80 per cent of these patients, of whom 80 per cent have mitral stenosis. Much less common are congenital and hypertensive heart lesions.

In pregnancy, do changes in circulatory dynamics occur?

Yes. A moderate tachycardia may be noted. This reaches its peak eight to twelve weeks before delivery. Cardiac output may increase as much as 30 to 50 percent, the maximum increase occurring in the last two to three months of pregnancy. The output then falls toward normal levels. Blood volume is highest eight to twelve weeks before delivery, as a result of an increase in both plasma and red cell volume. The plasma volume exceeds the red cell volume so that hemoglobin and hematocrit values are decreased. Finally, at the time of the increased cardiac output, there is a slight decrease in blood pressure (placenta acting as an A-V fistula).

During a normal pregnancy are there any changes in the distribution of the maternal blood flow?

Yes. The renal plasma flow is increased from 30 to 80 per cent early in pregnancy, but this shows a decline toward normal as the patient nears delivery. In late pregnancy the blood flow to the hands sometimes increases. At the same time the blood flow to the uterus is augmented and, as one would expect, the blood flow to the mammary glands is increased.

What cardiovascular changes occur during labor?

During the uterine contractions a 20 percent increase in the cardiac output may occur. A similar increase in pulmonary blood volume takes place, probably as the result of the squeezing of the blood out of the uterus.

What are the clinical findings in pregnancy when heart disease is not present?

A soft grade I or II basal systolic murmur may be noted. The heart sounds are accentuated, and a third heart sound may even appear early in diastole. There is usually a moderate tachycardia; the venous pressure is elevated in the extremities, and edema may appear if the intake of salt is unrestricted. Occasionally, an enlarged uterus may compress both diaphragms and cause rales to appear in the lung bases. A systolic bruit may be audible over branches of the mammary artery, and a continuous murmur is sometimes heard in the same area.

What are the clinical findings in pregnancy when heart disease is present?

Cardiac enlargement is demonstrable. A roentgen study may reveal a cardiac configuration suggestive of the etiologic background. Significant arrhythmias may appear. The most common complication in a pregnant cardiac patient is congestive heart failure. Consequently, as the pregnancy progresses, measures to prevent this complication should be prescribed, based on the over-all findings. When heart disease complicates a pregnancy, more frequent visits to the physician are necessary, particularly in those patients who are over thirty-five years of age. Then, with the co-

operation of a cardiologist, progress may be closely followed by electrocardiograms for comparison, together with other studies. In addition, the pregnant cardiac patient should be urged to enter the hospital at least two weeks before the expected date of delivery, so that the cardiac status may be under observation.

At what time is congestive cardiac failure apt to occur in these patients?

This complication may appear at the time of the maximal increase in cardiac output and heart rate. This is generally eight to twelve weeks before delivery. I believe that if the patient is asymptomatic after the seventh month, pulmonary congestion of cardiac origin is rare.

When the patient is suffering from rheumatic heart disease, what further complications should be looked for?

In addition to congestive failure and ectopic beats, reactivation of the rheumatic process, although rare at this time, should not be overlooked. Subacute bacterial endocarditis should also be kept in mind. In addition, pulmonary embolism remains a possibility, particularly when severe mitral stenosis is present.

■ William G. Leaman, Jr., M.D., questions Solomon S. Mintz, M.D., Attending Cardiologist, Albert Einstein Medical Center, Philadelphia, Pennsylvania.

■ William G. Leaman, Jr., M.D., Fellow, Council on Clinical Cardiology of the American Heart Association, edited this Brief for the Council on Scientific Advancement, in cooperation with the Pennsylvania Heart Association.

It's almost as if you were there to give an injection of penicillin



dependable oral penicillin therapy **V-Cillin K[®], Pediatric** Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin[®] (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K[®] (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K[®] (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [0425-67A] 800197

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206





Fig. 1. Partial air encephalogram taken in sitting position and showing partial block of air at second cervical level outlining lower border or herniated tonsils.

Occipital Neuralgia

MICHAEL SCOTT, M.D.
Philadelphia

Cervico-occipital pain, "occipital neuralgia," is a common complaint and the etiology is often vague and elusive. Many causes have been reported: flexion-extension injuries of the spine, pathology in the cervical muscles, fascia, vertebrae, or discs, hypertension, mastoid infection, diabetic neuropathy, polyneuropathies of varied etiology, tension headaches, psychoneurosis, postural factors and tumors of the high cervical cord and infratentorial fossa.

The following three cases suggest that severe and persistent bilateral cervico-occipital pain can be caused by congenital herniation of the cerebellar tonsils (Arnold-Chiari malformation). In the first patient there were no associated neurological abnormalities; in the second, the bilateral severe cervico-occipital pain led to needless surgery on both mastoids, and in the third patient, the choked disc and cerebellar signs suggested a

Intractable cervico-occipital neuralgia has a multiple etiology

space-taking lesion in the cerebellar fossa.

In all three patients the diagnosis was confirmed and the occipital pain relieved by decompressive craniectomy and upper cervical laminectomy. A minimum follow-up period of ten years in each patient, without recurrence of complaints, substantiated the diagnosis of the herniation of the tonsils as the causal factor.

Case Reports

Case No. 1: A white male, age twenty-five, was admitted to the Jewish Hospital on June 8, 1943. He had complained for a year of stiffness of his neck and sharp bilateral cervico-occipital pain worsened by sudden motion, straining or laughing. The pain often occurred during prolonged sitting, especially when playing cards. There were no paresthesias or motor complaints.

The family history was negative for similar complaints. His blood pressure was 120/80. A complete neurological examination showed no abnormalities. His cervical pain could be produced or intensified by compression of both jugular veins.

Roentgenograms of the skull and cervical spine were normal except for an increase in the distance between the posterior rim of the atlas and the spinous process of the axis (Fig 1).

Laboratory studies including blood count, urinalysis, and Wasserman were negative. The Queckenstedt test showed a partial block. The spinal fluid protein was 200 mgm. percent.

An air myelogram and encephalogram showed a partial filling of normal lateral ventricles and the subarachnoid pathways and a semicircular air pattern suggesting an extradural mass at the second cervical level (Fig. 1).

A suboccipital craniectomy and high cervical laminectomy were done on July 30, 1943. The posterior laminae of the atlas and axis, the posterior rim of the foramen magnum and bone over both cerebellar hemispheres were removed. The dura was opened over the cerebellar hemispheres and the upper spinal cord to the third cervical segment. The cere-

bellar tonsils were enlarged and had herniated 2.5 cm. below the foramen magnum. They were adherent to the posterior surface of the spinal cord by fine adhesions. The second cervical roots had been molded by the descending "tonsils" and served as a "hammock or sling" for them. Upon retraction of the "tonsils," part of the fourth ventricle could be seen in the posterior fossa. There was no evidence of tumor by inspection and tapping of the cerebellar hemispheres. The tonsils appeared adequately decompressed by the operation. The patient convalesced satisfactorily and was discharged free of headaches. He was examined on July 28, 1965, twelve years after the operation. He had no complaints but had returned for a recheck examination for insurance evaluation. The neurological examination was negative. The patient was again examined in 1966, twenty-three years after the operation. He had no complaints and the neurological examination was negative.

Comment

This patient's severe and persistent occipital neuralgia was not associated with any abnormal neurological findings. A screening spinal puncture and Queckenstedt test showed a partial block and a high spinal fluid protein of 200 mgm. percent. An air study showed an abnormal shadow in the upper cervical area. An exploratory suboccipital craniectomy and high cervical laminectomy revealed that this shadow was produced by the herniated tonsils (Arnold-Chiari malformation) which stretched the second cervical roots and caused the "occipital neuralgia." A reexamination of the patient, twelve and twenty-three years after operation, showed no recurrence of his cervico-occipital headaches or stiff necks.

Case No. 2: A thirty-one year old male was admitted to Temple University Hospital on March 2, 1955 complaining of severe pounding occipito-vertex headaches, photophobia, giddiness and vomiting of ten days duration. He had moderate headaches since childhood. His blood pressure was 140/80.

The neurological examination revealed normal pupillary and corneal reflexes. There was a slow coarse nystagmus on lateral gaze to either side. The visual fields were normal. There was bilateral choked disc of two diopeters. The cranial nerves including the vocal cords were normal. The deep tendon reflexes were increased on the right. There was no motor weakness. There was a right Babinski. Sensation was normal. Cerebellar tests showed a right intention tremor on finger to nose test. There was impairment of fine finger movements and hypotonia on the right. The gait was ataxic to the right.

The blood serology was negative. The blood urea was 10 mgm. percent and urinalysis was negative. A spinal puncture showed a pressure of 450 mm. of water. Clear fluid removed only from the manometer was acellular and insufficient for protein determination.

Skull, chest and upper cervical spine roentgenograms were normal. A suboccipital decompression in the sitting position was done on March 4, 1955. A ventricular tap showed clear fluid under high pressure. A bilateral suboccipital craniectomy included the posterior rim of the foramen magnum and atlas. The cerebellar hemispheres appeared normal but there was a herniation of both cerebellar tonsils, 3 cm. into the upper cervical canal, producing traction on the second cervical nerve roots. There were adhesions between the tonsils and the medulla. A cannula inserted into the right cerebellar hemisphere encountered clear fluid from the lateral recess of a large fourth ventricle. The vermis seemed full. It was split longitudinally and a large fourth ventricle was entered. It was thought then that the enlarged ventricle was due to an undetected slow-growing tumor in the vermis or to the Arnold-Chiari malformation. The dura was left open and a Torkildsen shunt procedure was done: A catheter was inserted into the right occipital horn, carried beneath the scalp and inserted into the upper cervical canal. Biopsies from the vermis and the cerebellar

Needless surgery should be avoided unless there is an indication for procedure

hemisphere were subsequently reported as normal tissue.

The patient was well at discharge. He has been followed periodically and was last examined on May 24, 1965, ten years after the surgery. He has been working regularly as an automobile salesman, has no complaints or headaches, and his vision was excellent. The suboccipital decompression was soft. The neurological examination was negative.

Comment

This patient's complete recovery following surgery with no recurrence of symptoms ten years later substantiates the original diagnosis of an Arnold-Chiari malformation with herniated tonsils which had caused his occipito-vertex headaches, cerebellar dysfunction and increased intracranial pressure.

Case No. 3: A female, age thirty-one, was admitted to Temple University Hospital on May 30, 1944, complaining of severe pounding suboccipital headaches radiating to the vertex and increasing in severity for two years. They usually occurred on standing and were partially relieved when she was recumbent. Coughing, sneezing and laughing increased the pain. She also complained of occasional "dizziness and swaying at times." There was no tinnitus. A right mastoidectomy was done in 1922 and a left mastoidectomy in 1943 for her occipital headaches without relief. The family history was negative for a similar condition. Her blood pressure was 134/90.

Examination showed the pupils equal and reacting well to light and accommodation. A horizontal nystagmus was present on looking to the left, and a counter clockwise rotatory nystagmus on looking to the right. There was decreased corneal sensation bilaterally. The visual fields and the eyegrounds were normal. There was a diminution to cold sensation in the first division of the trigeminal nerve bilaterally. The facial movements were normal. There was impaired hearing in the right ear because of the previous mastoidectomy. The tongue was protruded slightly to the right.

The gag reflex was absent bilaterally. The deep tendon reflexes were markedly increased with bilateral Hoffman and Babinski signs. There was bilateral hypalgesia of the third cervical dermatome. Sensation was otherwise intact. Motor function was normal. Cerebellar tests showed an ataxia on finger to nose and heel to knee test on the left. The patient veered to the left when walking.

Laboratory studies including complete blood count, urinalysis and blood Wasserman were negative. The spinal fluid examination was unsatisfactory. Roentgenograms of the skull showed bilateral mastoidectomies but were otherwise normal. Cervical spine films were not done. The Barány test suggested bilateral labyrinthine involvement.

A bilateral suboccipital exploration was done on June 16, 1944. The bone was removed over the cerebellar hemispheres, the posterior rim of the foramen magnum, and the posterior arch of the atlas and axis. The dura was opened over the cerebellar hemispheres, the medulla and upper cervical cord. The cerebellar hemispheres and vermis appeared normal. The cerebellar tonsils had herniated into the cervical canal 3 cm. below the foramen magnum and compressed the second cervical nerve roots. The tonsils were adherent to the dorsal surface of the medulla by white strands of adhesions which had to be sectioned. The fourth ventricle was not enlarged but it extended 2.5 cm. into the upper cervical canal. A catheter inserted into the fourth ventricle was gently passed 5 cm. cephalad without obstruction. The cerebellar hemispheres were tapped and there was no evidence of tumor or abscess. The left cerebellar tonsil was amputated to obtain adequate space for decompression. The dura was left open.

Subsequent examination of the cerebellar tissue showed mild congestion. The patient convalesced satisfactorily and she was discharged on July 20, 1944. A progress note made following the operation stated: "One speculates now whether or not the pain attributed to the 'mastoid infection' years ago was not actually root

pain caused by the pressure of the herniated tonsils against the second cervical nerve roots."

The patient was re-admitted to the hospital on June 14, 1946, two years later. She had complete relief of her headaches but six weeks before admission she noticed awkwardness and a sensation of pins and needles in the fingers of her right hand.

The neurological examination was normal except for the following: The patient had a bilateral Hoffman sign and in the right hand a loss of position sense, fine touch, stereognostic sense, and impairment of fine finger (skillful) movements and intention tremor with retention of motor function, pain, temperature, and vibration sense. The fact that this patient was comfortable for almost two years after her operation and suddenly developed new symptoms in her right hand six weeks before admission suggested that we were dealing with a new lesion.

An air study showed a partial block at the foramen magnum level. A re-exploration was done of the posterior fossa and the upper cervical cord. The dura was opened in the midline to the third cervical lamina. The underlying cerebellar tissue and the remaining right tonsil were adherent to the inner surface of the dura and were teased from it. The cord and medulla under this tonsil appeared distended. A needle was inserted in this area but no fluid was obtained. A small incision was made into its posterior surface and a cavity was entered measuring 1.5 cm. in length and 1 cm. in width and depth. There was no tumor or fluid in the cavity and its wall appeared glistening white. No biopsy was taken. A silver clip was placed at the lower end of this incision for future x-ray identification. It appeared that the cavity (syrinx) was the cause of the patient's new complaints in the right upper extremity. The dura was left open.

Examination fifteen days after the surgery showed no improvement from the pre-operative findings. In addition, there was complete absence of pin stick in the second division and partial absence of pin stick in the third division of the right trigeminal nerve

including the tongue. The right nasal mucosa showed a decrease in pain sensation and there was decrease to heat and cold in all three divisions of the trigeminal nerve on the right. A final diagnosis was made of syringomyelia (syrinx) involving the posterior lateral portion of the right upper cervical cord and medulla secondary to either pressure from the overlying remaining tonsil or from a disturbance in local circulation of unknown etiology. The patient did well and she was discharged on July 19, 1946.

She was last examined June 17, 1960, fourteen years later. She had no complaints and was doing her usual housework.

The neurological examination was normal except for delayed reaction bilaterally to corneal stimulation, decrease to touch over the ventral surface of the thumb, index and middle finger of the right hand, and some delay in stereognostic perception in this hand.

Comment

This patient had unnecessary bilateral mastoid operations which did not relieve her severe and persistent bilateral cervico-occipital pain. Decompression of the herniated tonsils produced prompt and lasting relief from her headaches.

An unusual neurological syndrome (see above) occurred two years after the intracranial operation due to a small syrinx in the dorso-lateral part of the medulla which was diagnosed and decompressed by surgery.

Examination fourteen years later showed no headaches or cervico-occipital pain and minimal residual sensory changes in the fingers of the right hand.

Discussion

There are reports in the literature of patients with Arnold-Chiari malformation or deformity, with or without bony vertebral involvement or congenital abnormalities of the nervous system, who had complained of cervico-occipital pain among other symptoms and who also had various degrees of neurological dysfunction.^{1, 4, 9, 7, 11} However, the fact that such herniation of the cerebellar tonsils in this malformation can irritate or stretch the second cervical nerve roots and cause severe and persistent high cervical and occipital pain has not been stressed in the past.

The writer believes that the three cases described above satisfy the cri-

teria listed by Chiari for his Type I malformation, namely "elongation of the cerebellar tonsils and inferior lobes enveloping the medulla and extending into the upper cervical canal, without downward displacement of the fourth ventricle."^{1, 3}

Those interested in theories concerning the embryologic origin of this condition are referred to articles by Bucy and Lichtenstein,² Gardner and Goodall,⁶ and Peach.¹⁰

Although observers such as Adams, *et al.*;¹ Epstein;⁵ Lewin *et al.*;⁷ and Teng,¹¹ have advocated opaque media for visualizing these lesions, our case No. 1 was diagnosed by partial air study, using cervical myelography combined with encephalography, in the upright position. Liliequist recently has reported the use of air encephalography in sixteen cases of Arnold-Chiari malformation.⁸ He states that in the forty cases of posterior fossa tumor,* the appearance of the herniated tonsils was that of rounded and broad soft tumor masses bulging into and completely filling the foramen magnum, whereas in the sixteen cases of Arnold-Chiari formation, the tonsils were narrow, elongated, pointed and often triangular in shape and did not completely block the passage of air into the cranium. However, the appearance of the tonsils in our case No. 1, Fig. 1 is an exception to Liliequist's observations, since the defect shown by the air

*The writer does not approve of the routine use of air encephalography in posterior fossa tumor cases because of the danger of additional herniation and respiratory failure.



■ Dr. Scott is professor and chairman of the department of neurological surgery at Temple University Health Sciences Center.

shadow indicates a broad and round mass which was proven to be due to a malformation of the tonsils rather than to tumor herniation.

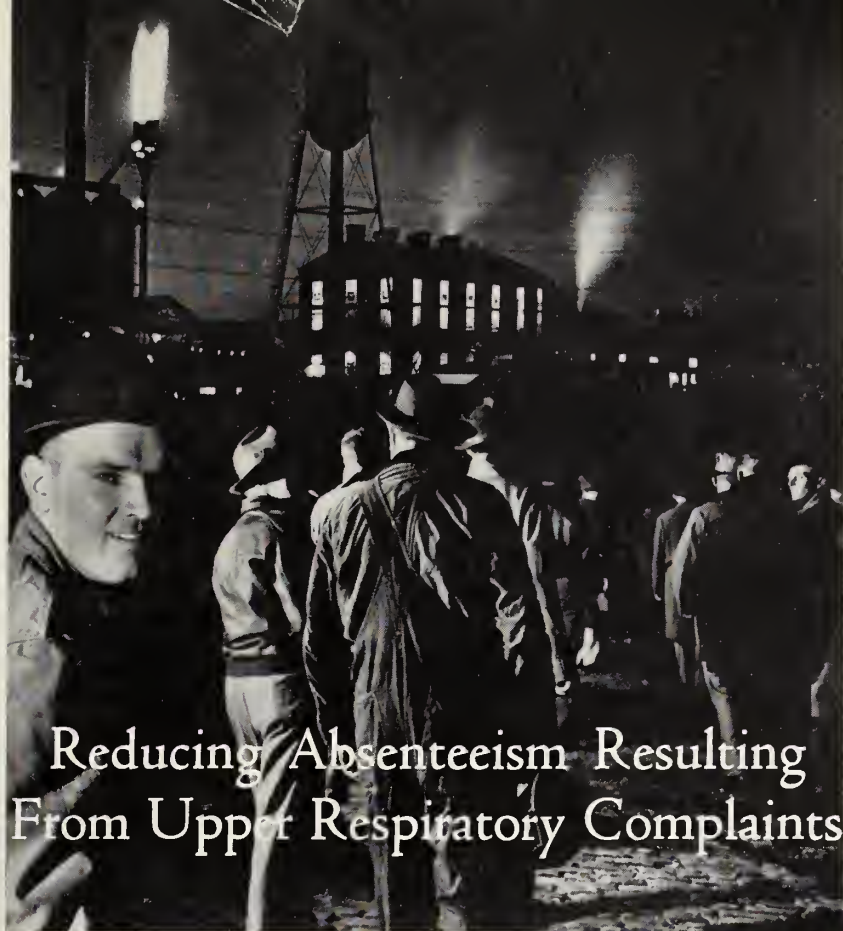
It appears that the malformation defect in the upper cervical canal can be visualized by air or opaque contrast media. The choice of the medium should depend upon the examiner's skill and experience in its use.

Conclusion

Intractable cervico-occipital neuralgia has a multiple etiology and every effort should be made to find the cause by appropriate medical and diagnostic studies. Needless surgery, such as mastoidectomy, cervical spine fusion, cervical disc exploration or occipital neurectomy should be avoided unless there are definite indications in addition to the occipital pain for these procedures. If extraspinal and intracranial causes cannot be found, and the pain is intractable, complete high cervical myelography including visualization of the foramen magnum area by pantopaque or air should be done to rule out a tumor or an Arnold-Chiari malformation with tonsillar herniation as a cause of the occipital "neuralgia," with or without associated neurological abnormalities.

REFERENCES

1. Adams, R. D., Schatzki, R., and Scoville, W. B.: The Arnold-Chiari malformation, *New England Jour. Med.* **225**: 125, 1941.
2. Bucy, P., and Lichtenstein, B. W.: Arnold-Chiari deformity in an adult without obvious cause *J. Neurosurg.* **2**: 245, 1945.
3. Chiari, H.: Über Veränderungen des Kleinhirns, des pons und der Medulla Oblongata in Folge von congenitaler Hydrocephalie des grosshirns. *Dtsch. Akad. Wiss. Wien.* **63**: 71, 1895; also *Deutsche med. Wchnschr.* **17**: 1172-1175, 1891.
4. Chorobski, J. and Stetien, L.: The syndrome of Arnold-Chiari. Report of a case, *J. Neurosurg.* **5**: 495, 1948.
5. Epstein, B. S.: Pantopaque myelography in the diagnosis of Arnold-Chiari malformation without concomitant skeletal or central nervous system defects, *Am. J. Roentgenol.* **59**: 359, 1948.
6. Gardner, J. W., and Goodall, R. J.: Surgical treatment of Arnold-Chiari malformation in adults explanation of its mechanism and importance of encephalography in diagnosis, *J. Neurosurg.* **7**: 199, 1950.
7. Lewin, J. R., Wycis, H. T., and Young, B.: Roentgen diagnosis of herniation of brain into spinal canal (Arnold-Chiari deformity) by pantopaque myelography, *Radiol.* **54**: 591, 1950.
8. Liliequist, B.: Encephalography in the Arnold-Chiari malformation. *Acta Radiol.* **53**: 17, 1960.
9. Parker, H. L., and McConnell, A. A.: Internal hydrocephalus resulting from a peculiar deformity of hind brain, *Tr. Amer. Neurol. Assoc.* **63**: 14-16, 1937.
10. Peach, B.: Arnold-Chiari malformation with normal spine *Arch. Neurol.* **10**: 497, 1964. *Ibid* **12**: 527, 1965.
11. Teng, P. and Papatheodorou, C.: Arnold-Chiari malformation with normal spine and cranium *Arch. Neurol.* **12**: 622, 1965.



Reducing Absenteeism Resulting From Upper Respiratory Complaints

DANIEL J. RANSOHOFF

COLIN KAMPERMAN, M.D., New Kensington

Absence from work represents a multi-billion dollar annual productivity loss which can never be regained,¹ according to a recent Conference on Absenteeism in New York City. The acute diseases such as colds and upper respiratory illnesses account for half of the current absenteeism in business and industry. At the Conference, Dr. Burt Brooks² emphasized that "a great step forward in absenteeism control will be taken when acute diseases can be controlled . . . Through research by the government, pharmaceutical companies, and scientists, great strides are anticipated . . . We will have a breakthrough in the treatment of generalized upper respiratory infections and even the common cold before too long."

Since such a large percentage of absenteeism is related to upper respiratory ailments and their concomitant nasal congestive states, any preparation which could reduce the congestion and cut the absenteeism rate is well worth adding to the industrial physician's office.

Recent pharmaceutical research literature stimulated our interest along

these lines with reports on the rather extensive clinical use³⁻⁷ of a new topical decongestant. The preparation, known as oxymetazoline hydrochloride (Afrin®*), is an imidazoline derivative which is very effective pharmacologically in very low concentration (1:2000). Reportedly, its vasoconstrictive effect is local, prompt, and prolonged with little or no rebound.

Method

We decided to evaluate this preparation from the standpoint of relief and value in nasal congestion and associated upper respiratory problems in those of our patients seen in the company infirmary.

The recorded study ran from January to November 1966 and included sixty individuals. The age range was eighteen to sixty-five, and the patients were equally divided as to sex. A large number of these patients had used other drugs prior to the use of oxymetazoline hydrochloride. Many of these other drugs were either ethical or proprietary compounds.

* Afrin® brand of oxymetazoline hydrochloride, Schering Corporation.

The outline of our plan consisted of a general subjective and objective evaluation of the product's clinical properties with reference to its pharmacological value and its efficacy in the relief of nasal and associated respiratory processes.

The patients were all examined prior to administration of oxymetazoline hydrochloride. As we noted, many of them had used other drugs with apparent ill effects. These side reactions were recorded in their individual records.

Although laboratory studies were not considered necessary, blood counts and urinalyses were performed on a large proportion of these patients since many of them were given complete physical examinations at initiation of or during the oxymetazoline study. Notes in regard to their physical findings were also kept in their individual records. In addition to the physical examination, blood pressures were taken on all patients before and after. During the evaluation, patients were re-examined, some of them several times.

Patient relief was rated excellent, good, fair, or poor. The criterion for "excellent" was considered as immediate and long-lasting relief of symptoms, immediately being within fifteen minutes and long-lasting, over twelve hours. The "good" rating consisted of relief achieved within slightly more than fifteen minutes with activity lasting from eight to twelve hours. The "fair" rating included those patients whose onset of relief occurred within one to two hours and lasted only four hours. "Poor" relief applied to those who either did not respond or required too long a time to respond. Side effects, if any, were noted.

Half of the patients were given oxymetazoline drops, and the other half were given the spray. Dosages ranged from two times a day to three times a day. Among the diagnoses were: common cold; chronic rhinitis; viral coryza; congested nasal passages; coryza and sinusitis; acute bilateral frontal sinusitis; frontal sinusitis; maxillary sinusitis (acute frontal sinusitis, acute coryza, mucoid bronchitis); acute L. sinusitis; and eustachian salpingitis (acute and chronic sinusitis and rhinitis, chronic recurrent serous otitis media, bullous tympanitis with otitis media, acute coryza, otitis media).

Results and Conclusions

In most instances, the onset of action was quite rapid. Within fifteen minutes, 70 percent of the patients noted rapid relief and a marked change in their symptoms. There were some patients who received relief as rapidly as five minutes. Relief lasted over eight hours, and in some instances longer than twelve hours, in over 50 percent of the patients.

Results were excellent in twenty-nine patients, good in twenty-two patients, fair in three patients and poor in six. Good to excellent prolonged relief was thus achieved in 85 percent of the patients, whereas only 17 percent of these same patients achieved this effect on other nasal decongestants.

Case Reports

The following illustrative cases based upon pre- and post administrative examinations indicate some of the interesting results we achieved with oxymetazoline hydrochloride:

Case #1, an obese sixty-year-old female with acute left frontal and maxillary sinusitis of three days' duration, was given oxymetazoline hydrochloride drops two times a day. Complete relief was achieved within fifteen minutes. She had no side effects whatsoever. Upon complete examination a week later, there were no physical findings. The patient indicated that symptoms had cleared after six applications. Interestingly, this patient is a hypertensive and on medication for hypertension. Her chart indicated that oxymetazoline therapy did not alter her blood pressure in any way.

Case #2, a twenty-three-year-old female, had subacute sinusitis for a period of two weeks with symptoms of headache, nasal stuffiness, and chronic post-nasal discharge. She had been using a commercially prepared nasal spray and capsules for a week at three to four times daily with no acceleration of resolution. She had marked hyperemic and succulent mucous membranes. Oxymetazoline drops were instituted on a two times a day basis. Onset of action occurred within fifteen minutes and lasted longer than twelve hours. The patient stated that she received immediate and permanent relief. She indicated extreme pleasure with the medication. The patient was rechecked one week from the date of original dispensing, and her physical examination was essentially normal at that time. She was

continued on the preparation for a few more days to see if there would be any rebound phenomenon. She called the infirmary three or four days later and indicated that she had stopped the medication. There was no recurrence of symptoms or indication of any stuffiness in her nose.

Case #3 is a slight departure from the ordinary. The patient was a thirty-three-year-old male, who had had acute right frontal sinusitis with lacrimal salpingitis for a period of two weeks. He had been using aspirin only. On examination, he showed very marked hyperemia and congestion of the mucous membranes with definite evidence of complete blockage of the right frontal sinuses and right lacrimal duct. Oxymetazoline spray was prescribed on a three times a day basis with no repeat. Although response was a little slow (it took about two hours for him to notice relief), when relief occurred, it lasted for more than twelve hours. He had had a great deal of pain in the right eye. Within the two hours of relief, the pain decreased and drainage occurred in the nose, indicating the lacrimal duct had opened. About four days later, he was re-examined. All symptoms had gone and he had returned to normal. The medication was discontinued. There has been no report of any exacerbation.

As we noted earlier, a variety of upper respiratory cases was included in this oxymetazoline study, including several instances of actual ear infection accompanied by congestion. Obviously, oxymetazoline did not cure the ear infection. However, it reduced congestion and opened the

drainage areas of the concomitant antibiotic therapy. In our opinion, the results are sufficiently interesting to suggest the performance of double blind studies combining an antibiotic in conjunction with this nasal decongestant in congestive ear infections.

Results with the drops and spray were fairly similar.

It is our feeling that a twice daily application would be adequate to control the majority of symptoms with the possible exception of one or two patients who may require a three times daily dosage.

Although patients using oxymetazoline chronically were cautioned against the possibility of secondary congestion, the usual rebound phenomenon or secondary congestion so often noted with other spray or drop decongestants was very rarely noted with oxymetazoline. Neosynephrine, particularly, is noted for inducing this phenomenon. Side effects were few. Discontinuance of oxymetazoline due to undesirable side effects occurred only once. Blood pressures were unaffected by the use of oxymetazoline.

Opinion

Based on our results, it is our opinion that oxymetazoline is a superior nasal decongestant with a more prompt and longer lasting effect than most preparations today. It should be particularly useful in reducing absenteeism from upper respiratory illnesses. It is an excellent drug which has supplanted all other nasal decongestants in our therapeutic armamentarium. Patients are particularly impressed with the fact that the preparation reduces nasal congestion sufficiently to provide them with a good night's sleep. As of this writing, we are prescribing oxymetazoline hydrochloride in at least 95 percent of our patients requiring topical nasal decongestant therapy.

REFERENCES

1. Longman, D. R.: Conference on Absenteeism, Hotel Americana, New York City, October 18, 1966.
2. Brooks, B.: Illness and absenteeism today, Conference on Absenteeism, *op. cit.*
3. Young, J. R.: A new nasal decongestant in otolaryngology, Eye, Ear, Nose & Throat Month, 46: 51-53, 1967.
4. Kuhn, A. J.: Evaluation of a new topical nasal decongestant, J. Indiana S. M. A. 59: 1295-96, 1966.
5. Ten Eyck, T. G.: Nasal decongestants in otorhinolaryngology, Western Med. 7: 158-59, 1966.
6. Haines, H. L.: Oxymetazoline spray in otorhinolaryngology. Curr. Therap. Res. 8: 91-93, 1966.
7. Mayer, P. S.: A prolonged acting topical nasal decongestant for various rhinitides, Illinois M. J. 129: 230-32, 1966.



■ Dr. Kamperman is medical director of the New Kensington Operations, Aluminum Company of America.



PENNSYLVANIA
MEDICINE

feature

Pennsylvania communities facing the need for new or expanded hospitals and related facilities are finding a new and welcome source of construction funds in the Appalachia Regional Development Program. Since June, 1966, more than \$4 million in Appalachia dollars have been approved to supplement building funds for medical and health projects costing approximately \$33 million for hospitals, community medical centers, schools of nursing, and vocational rehabilitation centers in the Commonwealth.

Pennsylvania has fifty-two counties eligible to receive grants for a variety of public purposes under the Appalachia Program. Only the fifteen southeastern counties are exempted from provisions of the Appalachian Regional Development Act (P.L. 89-4, of March 9, 1965, as amended by P.L. 90-103, of October 11, 1967).

Appalachia Helps Build Medical Facilities

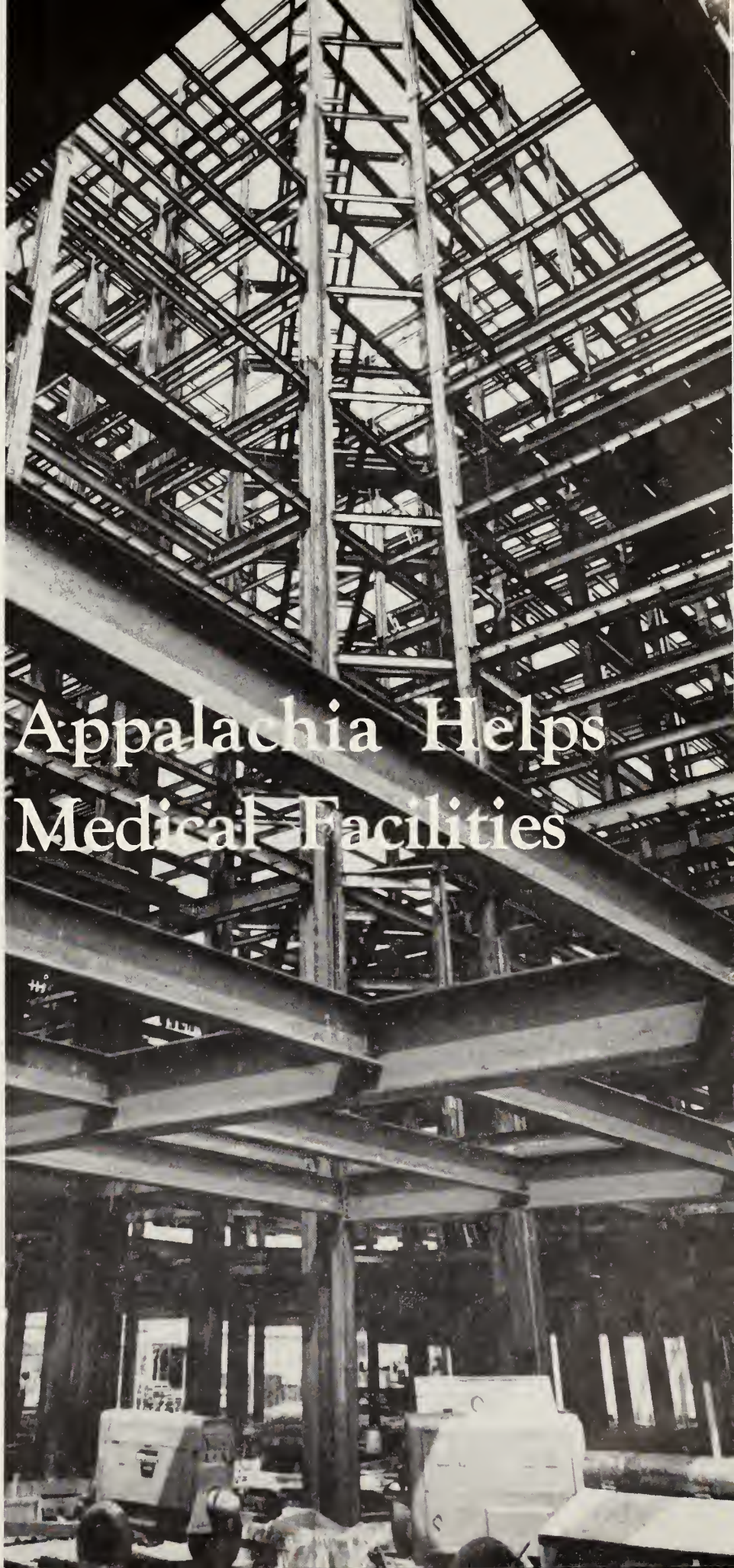
WILLIAM T. SCHMIDT

Executive Director,
Appalachia Program
Commonwealth of Pa.

Pennsylvania Appalachia is part of a region stretching from New York to Mississippi, including portions of thirteen states, which share common problems caused by geography and man-made conditions of economic dislocation. To help solve these problems the Appalachia States' Governors began as early as 1960 to work on plans for a unified effort to bring Appalachia's economic and social levels up to par with those of the Nation. The result was the formation of the Appalachian Regional Commission and passage of the Appalachian Regional Development Act of 1965.

The Appalachia Program represents a unique Federal-State co-equal partnership. It has served as the model for similar economic development programs recently established to serve

OCTOBER, 1968



Appalachia — Bricks and Mortar

other large regions of the United States. Secretary of Commerce Clifford L. Jones is the State Representative for Pennsylvania, representing Governor Raymond P. Shafer on the Appalachian Regional Commission which meets monthly to conduct its affairs, including approval of projects previously endorsed by the State in which the project is to be located.

These projects cover a variety of purposes. During 1967, Pennsylvania's Appalachia counties received \$41 million from the Commission for such non-medical projects as access roads, mine area restoration, vocational technical schools, sewage treatment plants, airports, colleges, and libraries. An additional \$37 million was authorized in 1967 for work on "Appalachia development" (i.e. major) highways in Pennsylvania.

The Appalachia program is concerned with facilities—"bricks and mortar"—to accommodate personal services to individuals.

In the field of medicine and health these facilities are for such purposes as mental health, vocational rehabilitation, hospitals, and nurses training education.

Extended care facilities are not given priority consideration in Pennsylvania, although the Appalachian Act does provide for grants for such facilities. The reason is that the Appalachian Commission has informed Pennsylvania that it is felt that the need for public grants to aid such facilities is not comparable in this State to what it is elsewhere in Appalachia. Pennsylvania has more private extended care facilities than do other states in Appalachia.

Since June, 1966, Appalachia grants have aided the construction—in Pennsylvania—of nine hospitals, four schools of nursing, and one community medical center. Projects for two additional hospitals and a vocational rehabilitation center have been submitted to the Appalachian Regional Commission.

Total cost of these projects is \$33,129,609. (Basic grants account for \$10,423,447 of this, Appalachia funding represents \$4,436,496; and local effort is supplying \$18,269,666).

Eleven mental health facilities in Pennsylvania have been funded by Appalachia since September, 1966, at a

total cost of \$6,558,752, of which \$2,308,730 represents basic grants, \$1,093,824 Appalachia funding, \$694,810 State monies, and \$2,461,388 local effort.

Because requests for Appalachia assistance exceed available funds and because (under Appalachia law and practice) funds must be invested where the anticipated return will be the greatest, it has been necessary to establish priorities, not only between projects but between types of projects. At the present time, vocational-technical schools are being emphasized under Pennsylvania's Appalachia program.

In August 1965 the Appalachian Regional Commission established a Health Advisory Committee, composed of experts in the health field.

Thomas Georges, Jr., M.D., Pennsylvania's Secretary of Public Welfare and Acting Secretary of Health, represents the Commonwealth on this Committee.

The task of the Committee has been to prepare an evaluation of the health needs and facilities in Appalachia and to recommend criteria for project preparation and selection.

Based in part on a study made within the last two years by this Committee showing that construction of new facilities is not as much needed as is the servicing of facilities already available, nurses training has been assigned priority attention in the field of medicine and health under the Appalachia grant program.

The Allegheny County School of Nursing project (see TABLE I) is particularly notable in that it represents for the first time cooperation between the Allegheny County School District and the Allegheny General Hospital for the education of these girls.

Vocational rehabilitation also has received priority consideration. The objective is to make patients into useful, productive citizens, able to support themselves.

The procedure for receiving Appalachia financial assistance begins with the filing of a letter of intent with the agency administering the basic grant program and the office administering the Appalachia program in the respective state.

When the Appalachia office is approached by the applicant it is pre-

pared to discuss the project, in person, with representatives of the applicant, as soon as it has definite assurance that the basic grant has been approved, or that the basic grant will be approved.

The application is then prepared and forwarded to the Appalachian Regional Commission in Washington for review and subsequent approval. Funds are disbursed through the basic grant agency.

Contracts cannot be let, nor can ground be broken, until notification of approval of the Appalachian grant has been received.

The first prerequisite for Appalachia supplemental aid for any type of medical or health facilities is that the project must have received, or be assured of receiving, a basic grant, under the Hill-Harris Act, the Nurses Training Act, the Mental Health Act, or the Rehabilitation Act.

To secure Appalachia supplemental funding for any of these facilities, economic justification for the project must be demonstrated. A need for the services that the project would provide is not sufficient.

For example, is the project located in an area of potential growth? One justification for Appalachia supplemental funding for the Titusville Hospital (for example) was the fact that Universal Cyclops was contemplating a \$25 million dollar plant in the community. The industry wanted assurance that it would have the necessary facilities to care for its employees.

Appalachia funding for medical and health facilities, as has been said, is *supplemental* funding. Hill-Harris can provide 33⅓ percent, Mental Health 50.02 percent, and Rehabilitation up to 75 percent. Appalachia participation has ranged between 3 percent and 16 percent.

A \$1 million dollar project might see \$333,000 in Hill-Harris funds, \$100,000 or \$150,000 in Appalachia funds, and the balance from local sources. All projects must have "local effort" of at least 20 percent. In most cases, local effort represents 40 percent to 50 percent of the cost.

Persons wishing additional information about Appalachia funding should contact the Director, Bureau of State and Federal Economic Aid, Pennsylvania Department of Commerce.

TABLE I
Medical and Health Facilities in Pennsylvania Aided by the Appalachia Program

Facility	County	Total Cost of Project	Basic Grant Funds	ARC Funds	Local Effort
Sunbury Community Hospital	Northumberland	\$961,380	\$300,000	\$150,000	\$511,380
Miners Hospital of Northern Cambria	Cambria	861,700	287,233	384,893	189,574
DuBois Hospital	Clearfield	2,761,500	700,000	250,000	1,811,500
Schuylkill County Rest Haven	Schuylkill	990,025	330,008	200,000	460,017
Mercy Hospital of Scranton	Lackawanna	1,880,600	600,000	200,000	1,080,600
Scranton Community Medical Center	Lackawanna	5,494,000	1,744,000	200,000	3,550,000
Palmerton Hospital	Carbon	2,200,000	500,000	100,000	1,600,000
Jersey Shore Hospital	Lycoming	1,017,500	339,167	145,000	533,333
Butler County Memorial Hospital	Butler	3,612,000	1,204,000	300,000	2,108,000
Gnaden Huetten Memorial Hospital	Carbon	1,160,000	267,000	100,000	793,000
*Vocational Rehabilitation Center of Allegheny County	Allegheny	2,206,521	166,738-VR 536,595-HH	400,000	1,103,188
*Titusville Hospital	Crawford	3,054,000	700,000	200,000	2,154,000
*Meadville City Hospital	Crawford	3,000,000	1,000,000	800,000	1,200,000
VR-Vocational Rehabilitation HH-Hill-Harris					
Allegheny General Hospital School of Nursing	Allegheny	1,109,620	308,833	439,620	361,167
Sharon General Hospital School of Nursing	Mercer	844,917	422,458	253,475	168,984
Conemaugh Valley Memorial Hospital School of Nursing	Cambria	860,000	459,492	228,508	172,000
Robert Packer Hospital School of Nursing	Bradford	1,115,846	557,923	85,000	472,923
	Totals	\$33,129,609	\$10,423,447	\$4,436,496	\$18,269,666

* As of May 2, 1968 these projects were pending approval by the ARC.

TABLE II
Mental Health Facilities in Pennsylvania Aided by the Appalachia Program

Facility	County	Total Cost of Project	Basic Grant Funds	ARC Funds	State Monies	Local Effort
Western Psychiatric Institute	Allegheny	\$1,380,000	\$687,930	\$295,404		396,666
Centerville Clinic	Washington	367,518	183,208	108,336		75,974
Robert Packer Hospital Mental Center	Bradford	129,529	64,570	38,742		26,217
Butler County Community Mental Health Center	Butler	424,200	211,464	126,878		85,858
Allied Services Community Residential Center for Mentally Retarded	Lackawanna	211,000	105,183	63,110		42,707
Clelian Heights School for Exceptional Children	Westmoreland	1,514,000	123,200	73,920		1,316,880
Mercer County Sheltered Workshop	Mercer	286,600	142,870	85,722		58,008
Erie Facility for Education and Training of Mentally Retarded	Erie	925,000	142,450	150,000	431,050	201,500
Mental Hygiene Clinic of Beaver County	Beaver	1,067,030	531,914	104,412	215,007	215,697
Bishop Sheltered Workshop, Jim Thorpe, Pa.	Carbon	66,975	22,771	12,056	18,753	13,395
General Hospital of Monroe County	Monroe	186,900	93,170	35,244	30,000	28,486
	Totals	\$6,558,752	\$2,308,730	\$1,093,824	\$694,810	\$2,461,388

Medical care is rapidly becoming a right, not a privilege of the individual. A good bit of the impetus has come about through the funding of medical care by various governmental agencies. As a result, there is much greater use of present medical facilities, and health manpower needs are being evaluated. One such study has been *The Report of the National Advisory Commission on Health Manpower*. As in all such reports, evaluations and recommendations have come from others. The AMA's Committee on Health Manpower has presented some comments about this report. In this presentation the object is to outline some of the major recommendations of the National Advisory Commission coupled with the AMA's thought on these matters. By so doing, it is hoped to stimulate the reader to some thoughts and conclusions of his own on the health manpower situation. Included in this discussion are some of the author's own thoughts. The proposals are grouped under four categories: Physician Supply, Education of the Health

talk. There is some doubt, however, about the AMA's response for the second part of their comment is a conjectural summary of the Commission's ninety-two-page report. Some funds must be found to increase the numbers of doctors. The choice is whether this money can come from the private purse or whether it should come from the federal coffers, and just what such funding would mean in regard to federal control of education.

A philosophy of medical school education is perhaps needed as to whether they are going to graduate teachers, researchers, or practitioners. Educational grants can be made so that graduates must go into private office practice and not a full time institutional status. The new medical school at Hershey, Pennsylvania, is selecting students for a family practice on graduation. Perhaps a lesson can be learned from the Hershey Medical School so as to provide the practicing physician needs.

Education of Health Professionals

Another commission proposal is:

has been law since 1966. Under this law, students may borrow up to \$2,000 per annum, which loan is to be repaid over a ten-year period starting three years after completing his education at which time a 2½ to 5 percent interest on the loan will start to accrue. In addition, the Health Profession Scholarship provides \$2,000-\$2,500 per year to 10 percent of the students of each class starting with the freshman class of September 1966 and increased by 10 percent of the number of the students in the class each year, thus making it 20 percent for the 1967 sophomore class and increasing to 40 percent of the class by graduation. These scholarships administered by the school according to the law are to be given strictly on need, not academic merit.

The AMA totally ignores the problem by hiding the clause, "admission with reference to family income," by supposing that every family is or should be financially able to educate a medical student. The AMA's loan program is sometimes difficult in this

Health Manpower

ALEXANDER M. MINNO, M.D.
Pittsburgh, Pennsylvania

Profession, Improving the Health Care System, and Foreign Medical Graduates.

Physician Supply

The Commission proposed: "Federal funds in support of capital or operating cost of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality. Such incentives should be based on increases in the absolute numbers of medical students."¹

The AMA's response to this is, "The Committee cannot endorse the concept of using federal funds as incentives solely for increasing the absolute numbers of medical students. This is inconsistent with other recommendations of the commission—that favor broad institutional support with greater emphasis on medical teaching than on research."²

If the AMA's assertion is true, then the Commission is involved in double

"The federal government should revise and expand present Health Professionals Education Assistance Programs to make available to any medical student loans to cover the full cost of tuition and living expenses during formal professional education. The student should be able to choose between repaying the loan from earnings over a period of years or giving two years of his time to approved national service apart from selective service."³

The AMA replies that "this expansion of support for medical students through federal funds would either increase the health manpower of the country or change the sources of medical school admissions with reference to family income . . . Further it is opposed to the use of indentured service in return for educational opportunities particularly since medical graduates are already obligated to long terms of both education and military service."⁴

The Commission's proposal ignores the already existing Health Manpower Loan and Scholarship Program which

respect; it is one wherein the student pays 6 percent or more in interest and the loan is repayable on completion of medical school. To be fair, however, it should be noted that the AMA loan programs operate from a private financial source, but the AMA guarantees the loan, therefore the higher interest rates. It is suggested that the private sector cannot be as generous in its support as the government and thus the federal funds can be made more attractive to the student, school, and public interest.

From what statistics are available, there does not seem to be an shortage of medical school applications. Perhaps scholarships on the basis of merit and not on need might attract the better student and thus allow the better academic students to consider medicine. A family income may be above the usual accepted loan-scholarship basis, but the family may have many children or other justified demands for their monies, and any support toward a medical school education would

place an undue financial hardship on the family.

In the same vein of education of physicians, the Commission states: "Formal education for all health professionals should be conducted under the supervision of universities (including) graduate training such as internships, residencies, and their equivalents."⁵

The AMA's response to this is to "agree that most of the formal education for health professionals should be conducted under the supervision of universities and colleges, but they believe there are proven advantages in the multi-center methods now in use. Furthermore, the capacity of universities and colleges to meet their educational responsibilities is limited for financial, physical, and personal reasons if they are to serve their essential teaching function."⁶

Here neither side comes to grip with the vital issue. Every year the residencies and internships in teaching hospitals are filled first; then the remaining positions are either filled by foreign trained medical students or are left vacant. On the other hand, the Commission ignores the fact that every hospital cannot be a teaching hospital since there would not be enough university faculty members to staff the teaching programs in every hospital.

It should not be forgotten that both the university hospital and the community hospital have unique educational opportunities for the graduate medical training program. One has the advantage of didactic teaching while the community hospital can provide routine medical needs. The residency training that does not allow for the demanding daily routine medical problems and deals only with the unusual will not provide the training for daily office practice needs. Also, by having teaching programs in community hospitals, the medical staff improves itself in order to adequately participate in the teaching programs. The side effect of a better community hospital is thus provided for the public interest and also our interest in public service.

Improving the Health Care System

The Commission recommended that "Innovations introduced experimentally for the care of the disadvantaged should be carefully examined for their applicability to the care of all persons. Conversely, programs for the care of the disadvantaged should incorporate elements from existing methods

of medical care, whatever appropriate."⁷

In response, the AMA replies: "The need for experimentation is clear and it clearly and strongly endorses the concept that it should incorporate elements from existing methods of medical care. The Committee (AMA committee) believes the problems of health care for the disadvantaged cannot be solved by "separate but equal" health care services or by any other device that disrupts the continuity and balance of health services throughout the community."⁸

Both the Commission and the AMA agree on this point. If any other policy was made the vogue, we would only further fractionate our health manpower so that instead of better services we would have less and less service as population increased. This is evidenced even now with the ever increasing delays that people must endure for appointments in order to be seen in the clinic.

It must be kept in mind always what being a doctor means. The manpower shortage is most acute and increasing. The demand for service creates a great burden on existing methods. Medical care is so personal that mass production or assembly line facilities have not been accepted by the public. Each person still feels his medical problem is important; he enjoys the personal care and is not confident or enthusiastic in the cookbook type of remedy.

Foreign Medical Graduates

On this issue the Commission recommends that "at a minimum, foreign-trained physicians who will have responsibility for patient care, should pass tests equivalent to those for graduates of U. S. medical schools. The National Board of Medical Examiners provides an objective testing service, service which should be utilized just as it is for graduates of U. S. schools. Issuance of an immigrant visa on the basis of third preference should be contingent upon satisfactory performance in the examination."⁹

The AMA believes this statement should have read as follows: "At a minimum, foreign-trained physicians who will have responsibility for patient care should pass tests to establish the fact that they have knowledge and skill equivalent to that possessed by graduates of U. S. medical schools."¹⁰

Here we have a critical issue. The Commission is proposing to upgrade the type of foreign medical personnel

serving in our hospitals while the AMA does not think we should be so stringent. If this matter were investigated a little further, we would see that many of the hospitals in this country have serving in them, foreign medical school graduates who have not passed the usual qualifying tests. There are several solutions to this problem. We could lower our standard of medical care and accept more and more unqualified foreign medical graduates. We could upgrade the requirements for foreign medical personnel and also increase our domestic crop of doctors by increasing the number of medical schools and the numbers we graduate. Finally, we could ignore the whole situation and require one set of standards for American educated medical students and another set for those who want to come from other countries to serve here.

Another point that recently has been presented by the AMA Council on Medical Education to the medical schools, is about the type of medical school training received by the foreign graduate. Inasmuch as the foreign medical graduate is able to pass (in many instances) all qualifying examinations and remain in the United States as a practicing physician, perhaps our medical school standards are too high? There are now so many foreign trained physicians in residency training and in practice that pressures are being applied for more medical student enrollments. By American standards, a good many foreign medical schools are poor indeed, and yet, these graduates can, and have, qualified to practice in the United States.

This is a fitting place to end the discussion. Because the whole paper is meant only to underscore the health manpower problem, no issues have really been solved. Such was never the intentions of these thoughts. We have just gathered them together to show what some of the thinking on health manpower is today. It is hoped that the reader will go away thinking about the five proposals which were made and perhaps come up with his own solution.

REFERENCES

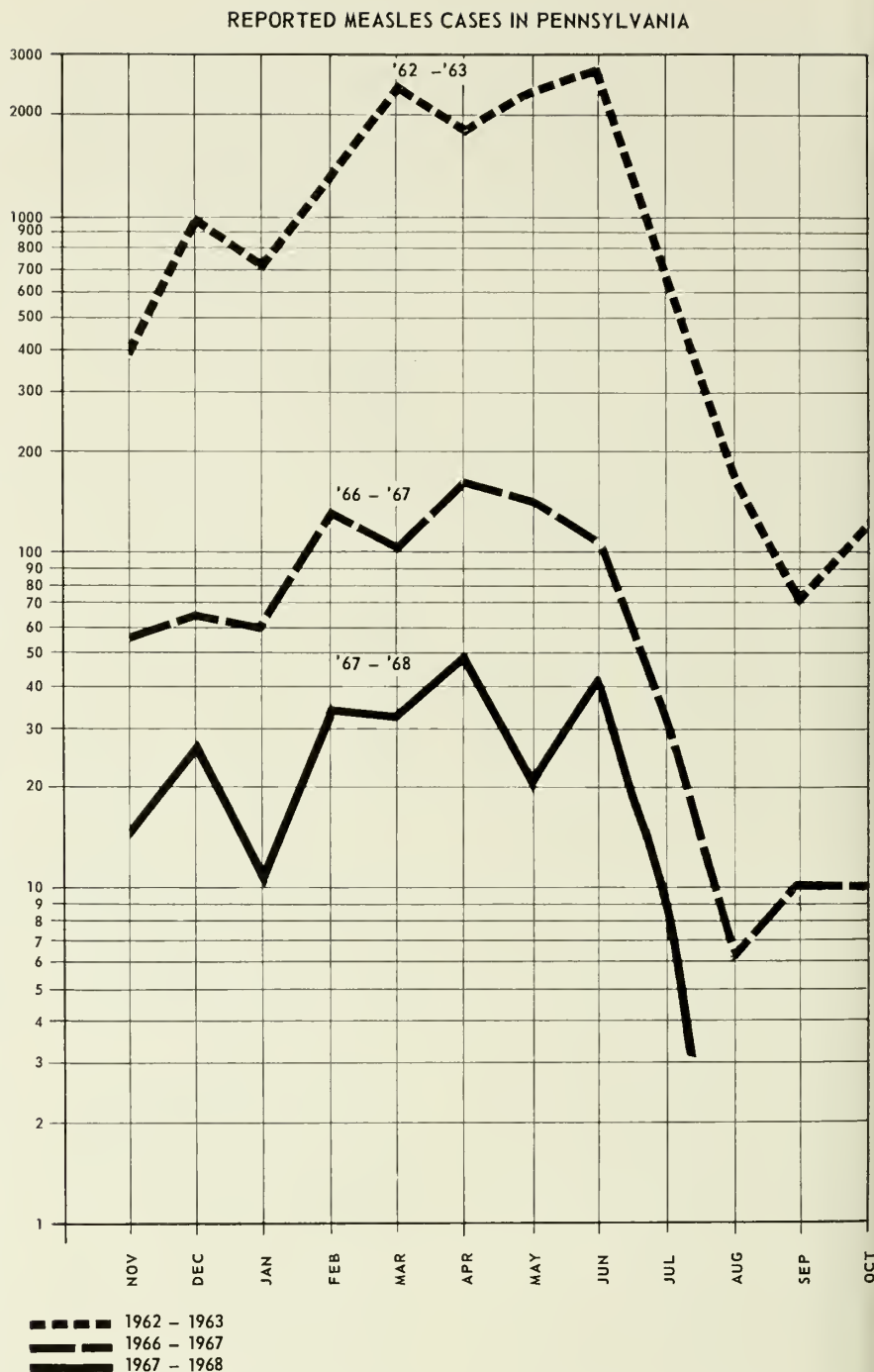
1. Report of the National Advisory Commission on Health Manpower, Vol. I, November 1967, p. 19 (United States Printing Office).
2. *The AMA News*, February 12, 1968.
3. *Ibid.*, Report, pp. 25-26.
4. *Ibid.*, *The AMA News*, p. 6.
5. *Ibid.*, Report, p. 31.
6. *Ibid.*, *The AMA News*, p. 6.
7. *Ibid.*, Report, p. 38.
8. *Ibid.*, *The AMA News*, p. 6.
9. *Ibid.*, Report, p. 43.
10. *Ibid.*, *The AMA News*, p. 6.

Rubeola Eradication In Pennsylvania

Nearly all children left unprotected by immunization will contract measles. In those children so infected, middle ear infection and bronchopneumonia are frequent complications. Further, encephalitis can be expected in 1 out of 10,000 cases. On a national level, there occur 400 deaths annually which are attributable to measles.

A federal bill, the Vaccination Assistance Act, was written in 1962 providing DPT and polio vaccines for the immunization of all susceptible preschool children. The Act was amended in 1965 to include measles vaccine. This meant that measles vaccine as well as polio vaccine and DPT could be provided for all preschool children. Since the physicians in private practice could not reach all children with the new vaccine and because many older children had not had measles, there was a large reservoir of susceptibles in Pennsylvania. As of January 1967 the number of susceptibles in Pennsylvania was estimated to be 400,000. This number would increase, as Pennsylvania births number 188,000 annually.

To reach these children, a concerted community effort was necessary. The Secretary of Health, in association with the PMS Council on Scientific Advancement, wrote to the presidents of fifty-two county medical societies and the chairmen of the nine districts of the Osteopathic Association early in the spring of 1967. This letter requested that physicians consider sponsorship of county-wide immunization programs within their respective counties. Assistance in planning, personnel, equipment and vaccine would readily be provided by the Department of Health upon request. Allegheny County's successful immunization of 52,700 of 78,000 susceptible children blueprinted the means for holding a program. That spring an effort was

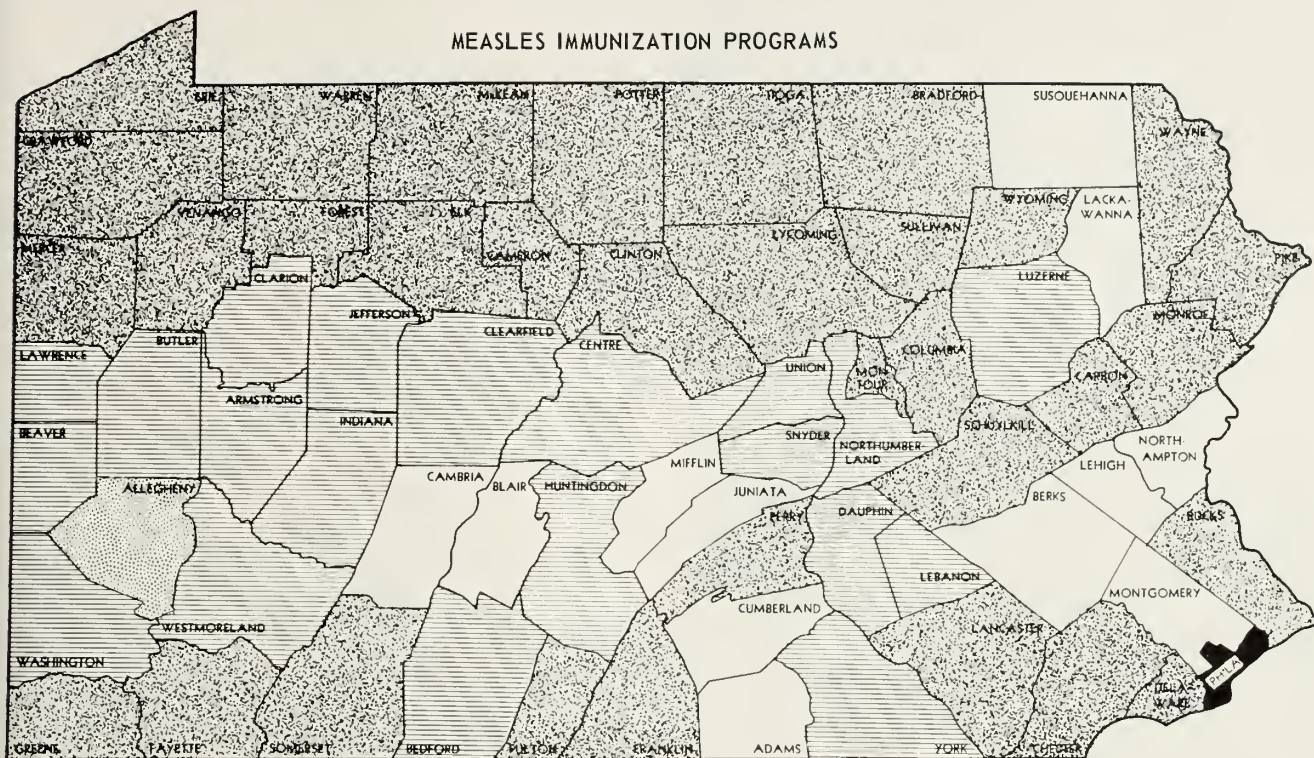


begun of which all participating physicians, nurses, and health department personnel can be proud—the effective control of measles through active immunization. Before school summer vacations temporarily halted programming, twenty-one counties organized and held such programs. In the past back to school meant back to measles for many children; there were still 320,000 susceptible children. The challenge was met with the scheduling of thirty-two additional programs from September 1967 to June 1968. To date, 148,237 children one through twelve

years have been immunized in these county programs. The figures exclude Allegheny and Philadelphia counties, which operate separate projects. These concentrated efforts toward measles control have led to a dramatic decrease in morbidity and have made significant inroads into our backlog of measles susceptibles. This is evidenced on the graph below.

With this much accomplished, what are the needs for immunization in those twelve counties which have not participated in programs? Based upon the response to the immunization pro-

MEASLES IMMUNIZATION PROGRAMS



ALLEGHENY COUNTY DEPARTMENT OF HEALTH PROGRAM, DECEMBER 4, 1966, 52,700 CHILDREN IMMUNIZED.
 SPRING - 67
 PHILADELPHIA MEASLES IMMUNIZATION - A CONTINUING PART OF MATERNAL AND CHILD HEALTH SERVICES
 FALL - 67 SPRING - 68
 REMAINING

TABLE I
REMAINING COUNTIES

	SUS. 1-12	MAX POS PART.*	MIN POS PART.#		SUS. 1-12	MAX POS PART.*	MIN POS PART.#
ADAMS	2865	2412	814	LACKAWANNA	11465	9653	3256
BERKS	14640	12327	4158	LEHIGH	11795	9313	3350
BLAIR	7255	6109	2060	MIFFLIN	2310	1945	656
CAMBRIA	9500	7999	2698	MONTGOMERY	28125	23861	7988
CUMBERLAND	6765	5696	1921	NORTHAMPTON	10545	8869	2995
JUNIATA	860	724	244	SUSQUEHANNA	1645	1385	467

* DERIVED FROM 84.2% OF COUNTY CHILDREN 1-12 YEARS SUSCEPTIBLE TO MEASLES.

DERIVED FROM 28.4% OF COUNTY CHILDREN 1-12 YEARS SUSCEPTIBLE TO MEASLES.

6 20, 68

grams held in the counties thus far, the Division of Communicable Diseases in the Department of Health believes that valid estimates of participation in future programs can be made. The poorest turnout could produce a total of 30,000 children whose parents are interested in having them immunized. The best possible participation would include 90,000 children (TABLE I¹). The consequences of not immunizing these children are obvious. It is hoped that it will be possible to conduct measles immunization programs in the twelve remaining counties before the next expected seasonal peak incidence of measles. In this light, the Department of Health reaffirms its support and assistance of programs with vaccine, personnel and equipment upon request.

One further significant fact remains. This is the continuing protection

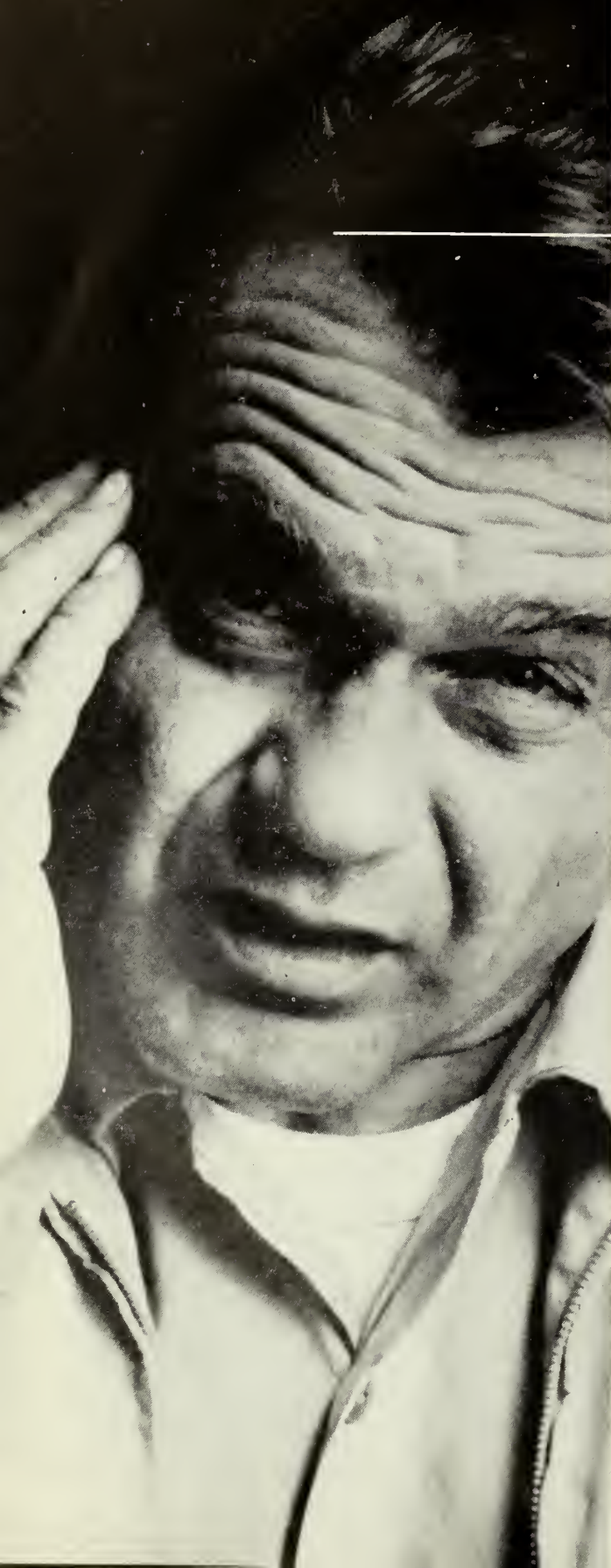
needed for infants entering the population eligible for immunization. Unless they receive vaccine, a new reservoir of susceptible children might be created. To meet this need, 175 child health clinics, Headstart and similar programs throughout the State are being supplied with vaccines. Educational materials and reminders are sent to the parents of all newborns encouraging them to seek immunization through their family doctors. However, the great majority of these children are cared for by private physicians. Measles vaccine for the immunization of preschool patients is available through the Community Vaccination Project of the Pennsylvania Department of Health.

As attention has become focused on measles, increased reporting of cases has resulted. Attempts are being made to verify the diagnosis of every case

because accurate reporting can give foreknowledge of possible epidemics and efforts begun to thwart them in their early stages. Since January, 166 cases of Rubeola have been reported to the Department of Health from all areas of the State. Of the 139 cases which have been investigated, thirty-five were found to be Rubella, allergic or other viral rashes.

¹ To make this forecast two percentages were needed. The fifty-three counties which have held programs were listed on a descending scale. This scale was based upon the percentage of participation—immunized children one through twelve years divided by the estimated susceptibles of each county. From the average of the thirteen counties highest in this listing, 84 percent or 46,956 children of the estimated susceptibles were immunized (total number immunized thirteen counties ÷ total number susceptibles thirteen counties). Similarly, from the thirteen counties lowestmost in this listing, an average of 28 percent was computed. By applying these two percentages to the estimated one through twelve year old susceptibles in the twelve counties where programs have not been held, the figures in the table were derived.

Is it depression?
He asks,
"Why do I have
these headaches?"



**...but his other symptoms:
functional somatic complaints,
anxiety, insomnia, loss of interest,
anorexia, feelings of guilt
strongly suggest
an underlying depression.**

when the diagnosis is depression

ELAVIL[®] HCl **(AMITRIPTYLINE HCl | MSD)**

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; for intramuscular use, in 10-cc. vials containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, and methylparaben 1.5 mg. and propylparaben 0.2 mg. added as preservatives.

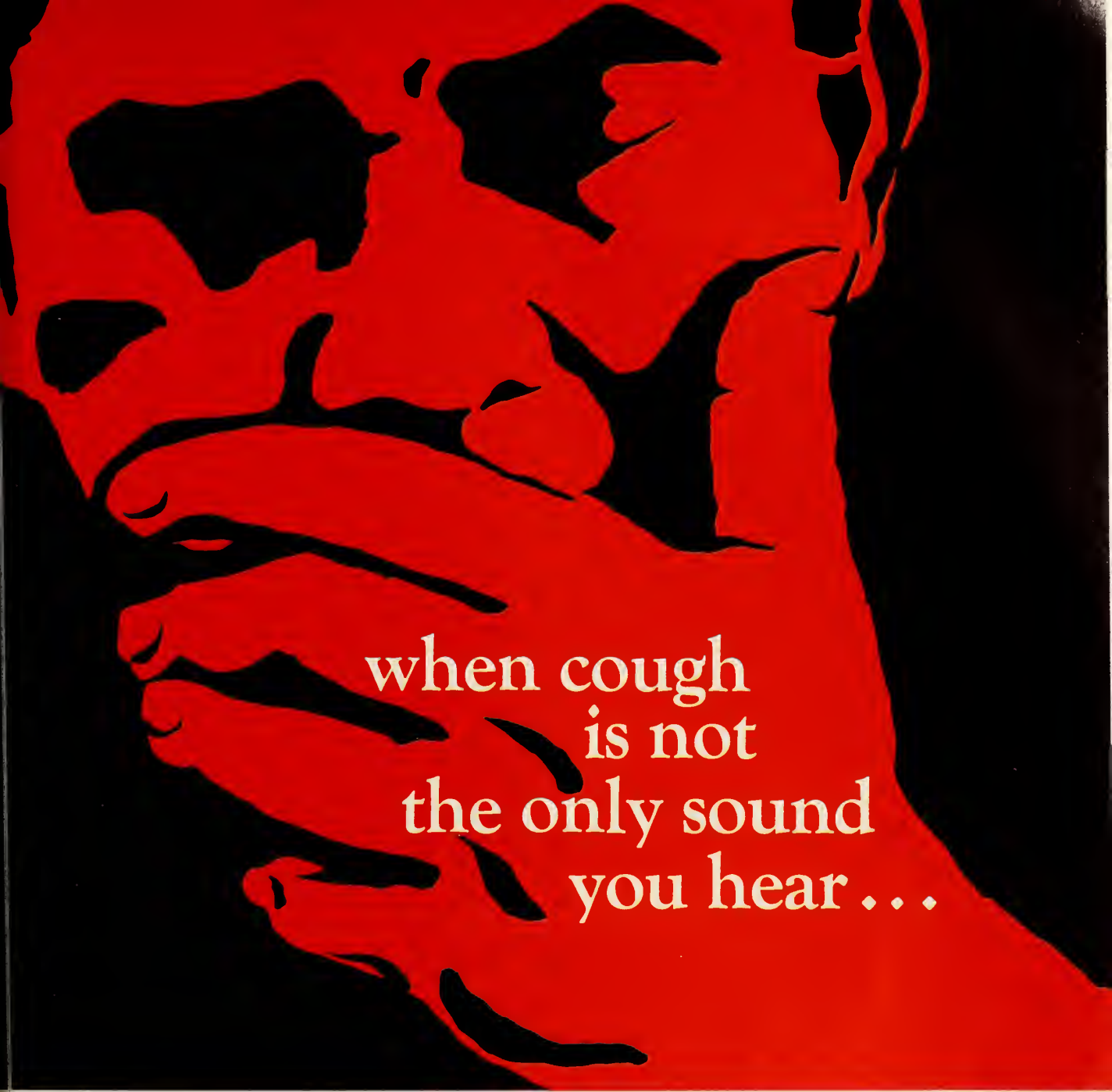
For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.



MERCK SHARP & DOHME

Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY



when cough
is not
the only sound
you hear...

OMNI-TUSS® b.i.d.

... **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiaicol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.

Children (6-12 years): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strassenburgh

Strassenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

In the complex picture
of moderate to severe anxiety...



there is a **new** reason
for prescribing **Mellaril**
(Thioridazine HCl)

**effectiveness in
mixed anxiety-depression**

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril[®]
(Thioridazine HCl)
25 mg. t.i.d.

**for moderate to severe anxiety
and mixed anxiety-depression**



SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J.

68-16



on call...

Keflin®
Sodium
Cephalothin



Eli Lilly and Company
Indianapolis, Indiana 46206



“The inconvenience of a cold”

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

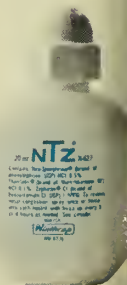
NTZ is more than a simple vasoconstrictor. It contains **Neo-Synephrine®** (brand of phenylephrine)

HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

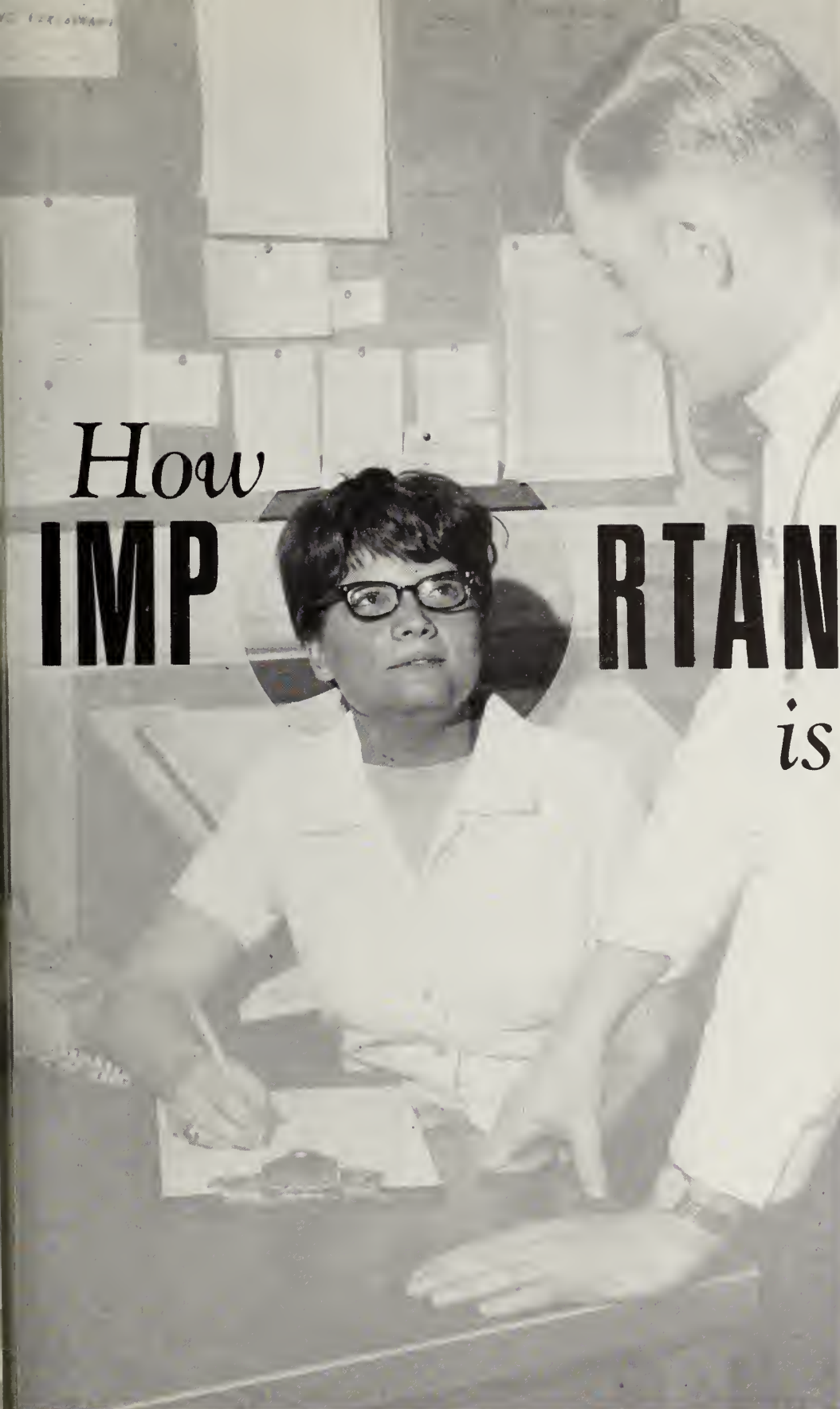
Thenfadiil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

Winthrop Laboratories, New York, N. Y. 10016



Winthrop



How
IMP

Your
**MEDICAL
ASSISTANT**

RTANT

is she?

When you think about all she does for you, she is almost like an extra set of hands! On top of all the things she now is doing, you can help her do a better, more efficient job. Encourage her to be active in the county, state and national Association of Medical Assistants.

Through her county Association of Medical Assistants and the Pennsylvania Association of Medical Assistants, your "Gal Friday" can pick-up valuable knowledge that will assist you and her in her everyday work at the office.

Give the Association of Medical Assistants your support . . . for the betterment of your extra set of hands!

**OBJECTIVES OF THE
ASSOCIATION of
MEDICAL ASSISTANTS**

To promote self-improvement of its members so that they can better serve the profession. ● To cooperate with the medical profession in improving its public relations. ● To inspire its members to render honest, loyal and efficient service to the profession and the public. ● To stimulate educational services for the betterment of its members.

For Further Information, Write: Pennsylvania Medical Society Council on Public Service



⊙ Indicates courses being conducted in Pennsylvania.

ALLERGY

⊙ **Practical Approaches to the Management of the Allergic Child;** by Jefferson Medical College, at Philadelphia, Wednesday, October 16-November 6, 1968; AAGP 2 hours applied for. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

⊙ **Allergies in Children;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, Wilkes-Barre, Wednesday, October 16, 1968. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

⊙ **Recent Advances in the Genesis of Asthma;** by Pennsylvania Medical Society and Pennsylvania Allergy Association; at Chatham Center, Pittsburgh, Tuesday, October 29, 1968; no fee. (Same as Internal Medicine—Electrolyte Metabolism and Renal Diseases.)

ARTHRITIS AND RHEUMATISM

⊙ **Newly Recognized Aspects of Rheumatoid Arthritis;** by Jefferson Medical College and Penn State University; at Pottsville Hospital, Thursday, October 10, 1968; 11:30 a.m. to 2 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

CARDIOVASCULAR DISEASE

⊙ **Cardiac Emergencies;** by Jefferson Medical College and Penn State University; at Mercy Hospital, Scranton, Wednesday, October 16, 1968; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

⊙ **Digitalis and Anti-Arrhythmic Drugs;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, November 4, 1968; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

⊙ **Drug Induced Complications of Heart Diseases;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, Wilkes-Barre, Wednesday, November 6, 1968. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

⊙ **Current Status of Vascular Grafting;** by Jefferson Medical College and Penn State University; at Pottsville Hospital, Thursday, November 14, 1968; 11:30 a.m. to 2 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson

son Medical College, 1025 Walnut Street, Philadelphia 19107.

CHEST DISEASES

⊙ **Courses in Bronchoesophagology;** by Temple University School of Medicine and Hospital; at Temple University Health Sciences Center, 3401 N. Broad St., Philadelphia, Monday, October 14-25, 1968, Monday, January 13-24, 1969, Monday, April 14-25, 1969. Fee for Course \$350. Contact Charles M. Norris, M.D., or Gabriel F. Tucker, Jr., M.D. at Chevalier Jackson Clinic, Temple University Hospital, 3401 N. Broad St., Philadelphia 19140.

⊙ **Clinical Pulmonary Physiology and Its Relationship to Treatment;** by Jefferson Medical College and Penn State University; at Williamsport Hospital, Wednesday, October 16, 1968; 11:00 a.m. to 2:30 p.m.; AAGP 3 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

⊙ **CPC and Restrictive Disease of the Lungs;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, October 21, 1968; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

⊙ **Management of Respiratory Failure;** by Hahnemann Medical College and Grand View Hospital, Sellersville; at Grand View Hospital Nurses Home, Sellersville, Wednesday, October 23, 1968. Contact D. Henry Ruth, M.D., Grand View Hospital, Sellersville, Pa. 18960.

⊙ **M/M and Industrial Lung Disease;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, October 28, 1968; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

ENDOCRINOLOGY

⊙ **Oral Agents in the Management of Diabetes Mellitus;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, October 7, 1968; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

⊙ **Newer Concepts of Thyroid Disease;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, November 11, 1968; 2:00 to 5:00 p.m.;

AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

GASTROENTEROLOGY

⊙ **Medical and Surgical Aspects of Gastrointestinal Problems;** by Jefferson Medical College and Penn State University; at Voyager Motor Inn, Franklin, Wednesday, October 30, 1968; ward round at Franklin Hospital; fee \$5; AAGP 3 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

GENERAL

⊙ **Recent Advances in Medicine;** at Temple University Health Sciences Center, Philadelphia, Wednesday, October 16, 1968, 8 days, 32 hours; fee \$50. AAGP credit applied for. Contact Albert J. Finestone, M.D., Temple University Health Sciences Center, Broad & Ontario Sts., Philadelphia 19140.

⊙ **New Frontiers in Medicine;** by Philadelphia Academy of General Practice; at Marriott Motor Inn, Bala Cynwyd, Sunday, November 3, 1968; AAGP 6 hours; fee \$10. Contact Milton M. Perloff, M.D., Philadelphia Academy of General Practice, 2923 W. Cheltenham Ave., Philadelphia 19150.

⊙ **Hospital Liability Law;** by The Pittsburgh Institute of Legal Medicine, The Practicing Law Institute and The Institute of Forensic Sciences of Duquesne University, at Chatham Center, Pittsburgh, Friday and Saturday, November 8-9, 1968. Contact Cyril H. Wecht, M.D., LL.B., Director, The Pittsburgh Institute of Legal Medicine, 1417 Frick Bldg., Pittsburgh 15219.

GENETICS

⊙ **An Introduction to Medical Genetics;** by Jefferson Medical College and Penn State University at Conemaugh Valley Memorial Hospital, Johnstown, Tuesday, October 22, 1968; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

⊙ **General Internal Medicine;** by Hahnemann Medical College; at Philadelphia, Wednesday, October 16, 1968-April 16, 1969; fee \$150 for 75 hours AAGP credit. Contact Wilbur W. Oaks, M.D., Hahnemann Medical College, 235 N. 15th St., Philadelphia 19102.

○ **Renal Disease: Pathologic Physiology**; by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, October 17, 1968*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Current Concepts of Thyroid Disease**; by Jefferson Medical College and York Hospital; at *York, Thursday, October 24, 1968*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Two day visit, October 24 and 25. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Electrolyte Metabolism and Renal Disease**; at Chatham Center, *Pittsburgh; Sunday and Monday, October 27 and 28, 1968*; fee for course \$25, non-members \$35. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

○ **Seminar on Renal Diseases**; by Pennsylvania Medical Society; at Chatham Center, *Pittsburgh, Monday, October 28, 1968*; fee for course \$5, students—free. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

○ **Renal Biopsy and Responses of Renal Tissue**; by Pennsylvania Medical Society, Pennsylvania Society of Internal Medicine and American College of Physicians; at Chatham Center, *Pittsburgh, Tuesday, October 29, 1968*; no fee. (Same as Internal Medicine—Electrolyte Metabolism and Renal Diseases.)

○ **Clinical Use of Diuretic Drugs**; by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, *Wilkes-Barre, Wednesday, November 6, 1968*. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

○ **Diagnosis & Treatment of Hepatitis**; by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, *Wilkes-Barre, Wednesday, October 30, 1968*. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

○ **Differential Diagnosis of Jaundice**; by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, *Wilkes-Barre, Wednesday, October 30, 1968*. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

○ **Clinical Renal Physiology**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, October 14, 1968*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jeffer-

son Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Renal Disease: Medical Management & Surgical Indications**; by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, November 7, 1968*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

MALIGNANT DISEASE

○ **Cancer Detection in Office Practice**; by American Cancer Society, Philadelphia Division, Inc., at American Oncologic Hospital, *Philadelphia, Wednesday, October 23-November 20, 1968*; AAGP 20 hours credit; no fee; minimum number required, maximum permitted 10. Contact Joseph G. Strawitz, M.D., American Oncologic Hospital, Central and Shelmire Aves, Philadelphia 19107.

MICROBIOLOGY & IMMUNOLOGY

○ **Recent Advances in Immunization**; by Hahnemann Medical College and Luzerne County Academy of General Practice; at Wyoming Valley Hospital, *Wilkes-Barre, Wednesday, October 16, 1968*. Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

NEUROSURGERY

○ **Continuing Education Course**; by Pennsylvania Medical Society and Pa. Orthopaedic Society; at Chatham Center, *Pittsburgh, Tuesday, October 29, 1968*. No fee. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

OBSTETRICS & GYNECOLOGY

○ **Office Gynecology**; by Jefferson Medical College; at *Philadelphia, Tuesday, November 12-December 17, 1968*; 12 course hours; AAGP credit applied for; fee \$50; minimum number required 30, maximum permitted 100. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

OPHTHALMOLOGY

○ **Nystagmus—Differential Diagnosis, Implications and Treatment**; by Pennsylvania Medical Society and Pa. Academy of Ophthalmology and Otolaryngology; at Chatham Center, *Pittsburgh; Tuesday, October 29, 1968*. No fee. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

ORTHOPAEDICS

○ **Office Management of Common Minor Shoulder, Knee and Foot Problems**; by Pennsylvania Medical Society

and Pa. Academy of Physical Medicine and Rehabilitation; at Chatham Center, *Pittsburgh, Tuesday, October 29, 1968*. No fee. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

PHARMACOLOGY

○ **Clinical Pharmacology of Cardiac Drugs**; by Jefferson Medical College and Penn State University; at *Allentown Hospital, Thursday, October 10, 1968*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

○ **Applied Office Psychiatry**; by The Institute of the Pennsylvania Hospital; at *Allentown Hospital; Thursday, October 17, 1968-June 19, 1969*; 10 a.m.-1 p.m.; AAGP credit applied for. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Advanced Seminar in Adult Office Psychiatry—Course #2**; by Temple University Health Sciences Center, *Philadelphia, Wednesday, November 6, 1968 to January 22, 1969*; AAGP 30 hours; fee \$30; maximum number permitted 10. Contact Barney M. Dlin, M.D., Temple University Health Sciences Center, Broad and Tioga Sts., Philadelphia 19140.

○ **The Physician and Sex Education—Part II**; by Jefferson Medical College and York Hospital; at *York, Thursday, November 7, 1968*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Psychodynamics of Physicianhood**; by Pennsylvania Medical Society and Pa. Psychiatric Society at Chatham Center, *Pittsburgh, Tuesday, October 29, 1968*. No fee. Contact J. A. Collins, Jr., M.D., Chairman, Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne 17043.

○ **Psychiatry for the General Practitioner**; by Temple University Health Sciences Center; at Marriott Motor Hotel, *Philadelphia, Saturday, November 2 and 3, 1968*; AAGP 13 hours; fee \$20. Contact Barney Dlin, M.D., Temple University Health Sciences Center, Broad & Ontario Sts., Philadelphia 19140.

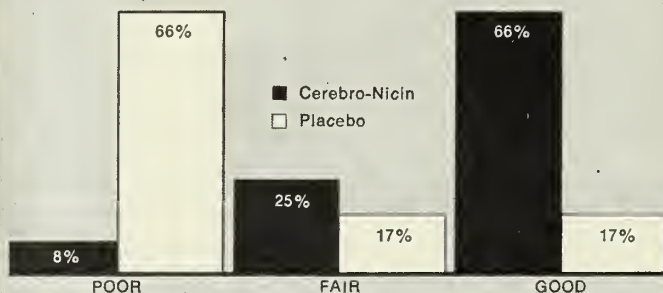
● All organizations presenting continuing education programs for physicians are invited to list details of these programs in PENNSYLVANIA MEDICINE. Programs will be listed up to one year in advance. Information must be submitted three months in advance to assure publication. Please submit a separate request for each program. Continuing Medical Education Publication Request forms are available from the PMS Council on Scientific Advancement, Taylor Bypass and Erford Road, Lemoyne, Pa. 17043.

For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin® capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jr., of the Amer. Ger. Soc., June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylentetrazole.....	100 mg.
Nicotinic Acid.....	100 mg.
Ascorbic Acid.....	100 mg.
Thiamine HCl.....	25 mg.
L-Glutamic Acid.....	50 mg.
Niacinamide.....	5 mg.
Riboflavin.....	2 mg.
Pyridoxine.....	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir pint bottles.

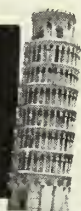
CONTRAINDICATIONS: There are no known contraindications to Pentylentetrazole although caution should be exercised when treating patients with a low convulsive threshold. Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

Write for literature and samples...

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog



in the treatment of
IMPOTENCE



Android®
(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS - Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths
Android

Each yellow tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . . 5.0 mg.
Thyroid Ext. (1/2 gr.) . . 30 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN
Android-E

Each Tablet Contains:
Methyl Testosterone 2.5 mg.
Ethynyl Estradiol 0.02 mg.
Thyroid Ext. (1/6 gr.) . . . 10 mg.
Thiamine Hydrochloride . . 10 mg.
Glutamic Acid 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen - only steroid effect remains. Geriatrics, post-operative and debilitated disease, osteoporosis OOSE: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRAINDICATIONS: See Android. Ethynyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057



SAFEGUARD AGAINST BREAST CANCER

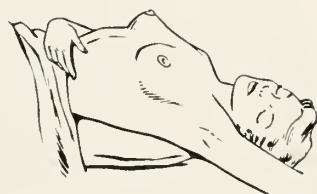
"TEACH HER HOW AND DO IT NOW"
ADVISE BREAST SELF-EXAMINATION MONTHLY



Inspect breast for normal contour and appearance. Asymmetry, puckering, dimpling or nipple retraction can be noted.



Repeat visual examination with arms raised.



Recline on bed and elevate shoulder with pillow or folded towel, under side to be examined.



With arm above head examine inner half of breast with flat of fingers. Start at clavicle and move to xiphoid in a series of steps.



Palpate the nipple.



With arm lowered, examine outer half of breast from axilla to xiphoid. Repeat steps 3-6 on the opposite side.

**AN ALERT PHYSICIAN-PATIENT TEAM
IS THE
KEY TO CANCER CONTROL**



R. C. Eyerly, M.D., Associate in Surgery, Geisinger Medical Center Consultant.

AMERICAN CANCER SOCIETY

PENNSYLVANIA DIVISION

PHILADELPHIA DIVISION

PENNSYLVANIA CANCER FORUM PAGE—presented cooperatively by the Council on Scientific Advancement of the Pennsylvania Medical Society, the Pennsylvania and Philadelphia Division of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health.

This advertisement for TAO[®] (tri-acetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

TAO[®](triacetyloleandomycin)

Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017



PENNSYLVANIA
MEDICINE

meetings

OCTOBER

- PMS Annual Scientific Sessions, October 27-29, 1968, Chatham Center, Pittsburgh.
- Annual Session, American Society of Anesthesiologists, October 19-23, 1968, Washington, D.C.
- Second National Congress on Medical Ethics, AMA Judicial Council, October 5-6, 1968, Drake Hotel, Chicago.
- 37th Annual Meeting, American Academy of Pediatrics, October 19-24, 1968, Chicago.
- Tenth International Congress on Diseases of the Chest, October 4-8, 1968, Washington Hilton Hotel, Washington, D.C.
- 75th Convention, Association of Military Surgeons, October 21-23, 1968, Sheraton Park Hotel, Washington, D.C.
- 33rd Annual Meeting, Industrial Hygiene Foundation, October 15-16, 1968, Chatham Center, Pittsburgh.
- American College of Obstetricians and Gynecologists District Meeting, October 17-19, 1968, Bellevue-Stratford Hotel, Philadelphia; October 16-18, 1968, Pittsburgh-Hilton Hotel, Pittsburgh.
- Annual Conference, American Social Health Association, October 27-28, 1968, Biltmore Hotel, New York City.
- Eleventh Congress, Pan-Pacific Surgical Association, October 14-22, 1968, Honolulu, Hawaii.
- Annual Clinical Congress, American College of Surgeons, October 21-25, Atlantic City, N.J.
- Annual Session, American Association for Laboratory Animal Science, October 21-25, 1968, Stardust Hotel, Las Vegas, Nevada.
- 33rd Annual Meeting, Industrial Hygiene Foundation, October 15-16, 1968, Chatham Center, Pittsburgh.
- First Annual Childrens Orthopaedic Meeting, October 5, 1968, State Hospital for Crippled Children, Elizabethtown.

NOVEMBER

- PMS Speakers' Bureau Seminar, November 13, 1968, PMS Headquarters, Lemoyne.
- 47th Annual Convention, National Easter Seal Society for Crippled Children and Adults, November 13-16, 1968, Boston.
- 16th Annual Scientific Meeting, American Society of Cytology, November 7-9, 1968, Cleveland.
- Annual Meeting, American Public Health Association, November 11-15, 1968, Detroit.
- Conference on Respiratory Therapy, American Society of Anesthesiologists, November 6-9, 1968, Statler-Hilton Hotel, Boston.
- American College of Surgeons, Eastern Pennsylvania Chapter Annual Meeting, Nov. 13, 1968, Abraham Lincoln Hotel, Reading.
- 14th Annual Meeting, American Association for Inhalation Therapy, November 10-15, 1968, Houston.



⊙ Indicates membership in the Pennsylvania Medical Society at time of death.

Frank M. Chesner, Merion Station; Jefferson Medical College, 1913; age 76; died July 31, 1968. Dr. Chesner was associated with the Albert Einstein Medical Center's Southern Division and Pennsylvania Hospital. His wife survives.

Albert W. Laigon, Coaldale; Jefferson Medical College, 1937; age 58; died August 1, 1968. Dr. Laigon was school physician for the Panther Valley School District. He is survived by two sisters and a niece.

Mary Mackey Miller, Portage; Medical College of Virginia, 1930; age 63; died July 22, 1968. Dr. Miller is survived by her husband, a son and a daughter.

Homer P. Prowitt, Washington; Western Reserve School of Medicine, 1908; age 84; died April 17, 1968. We have received no information regarding survivors.

⊙ **Edward C. Viner**, Philadelphia; University of Pennsylvania School of Medicine, 1942; age 50; died July 13, 1968. Dr. Viner was the founder of West Park Hospital and on the staff of the Southern Division, Albert Einstein Medical Center and Woman's Medical College Hospital. Survivors include his wife, two daughters, a son and a sister.

⊙ **Abe K. Weaver**, Tarentum; Jefferson Medical College, 1917; age 76; died July 4, 1968. Dr. Weaver was active in community affairs and had served in the Army Medical Corps during World War II. We have received no information regarding survivors.

⊙ **George E. Biskup**, Mt. Pleasant; University of Pittsburgh School of Medicine, 1938; age 53; died August 14, 1968. Dr. Biskup was a veteran of World War II. He is survived by his wife, four sons and a daughter.

⊙ **James T. Gallagher**, Palmyra; University of Pittsburgh School of Medicine, 1938; age 54; died August 7, 1968. Dr. Gallagher was a member of the American Academy of General Practice and the Hershey Hospital medical staff. Surviving are his wife, a son, two daughters, a sister and four grandchildren.

⊙ **Cyrus C. Leydic**, Natrona Heights; Jefferson Medical College, 1908; age 89; died July 27, 1968. Dr. Leydic was on the staff of Allegheny Valley Hospital and a member of its board of directors. He served as school physician for Harrison Township School District for fifty years. Survivors include his wife, a son and a daughter.

⊙ **Ralph P. Matter**, Covington; Jefferson Medical College, 1927; age 82; died July 23, 1968. Dr. Matter was an honorary member of the staff of Blossburg State Hospital. Surviving are his wife, a daughter, a son, three sisters, two brothers and six grandchildren.

⊙ **Charles A. Miller, Jr.**, Allentown; Jefferson Medical College, 1949; age 42; died August 12, 1968. Dr. Miller was assistant plant surgeon of the medical division of the Bethlehem Steel Corporation. He was on the staffs at Allentown, Sacred Heart and St. Luke's hospitals and formerly was chief surgical resident at Sacred Heart. He was a diplomate of the American Board of Surgery and former Lehigh County deputy coroner. Surviving are his wife, a son and three daughters.

⊙ **Thomas E. Murray**, Chester; Hahnemann Medical College, 1921; age 75; died August 12, 1968. Dr. Murray was former chief of medicine at Crozier Hospital and a veteran of World War I. He is survived by his wife, two sons, a daughter, a brother, a sister and eighteen grandchildren.

⊙ **William H. Rodgers, Jr.**, Philadelphia; University of Toronto School of Medicine, 1927; age 68; July 25, 1968. Dr. Rodgers is survived by a son, a brother and four grandchildren.

⊙ **Joseph P. Fisher**, Glassport; University of Maryland School of Medicine, 1952; age 54; died August 6, 1968. Dr. Fisher is survived by his wife and a daughter.

⊙ **Jules T. Vogel**, Havertown; University of Pennsylvania School of Medicine, 1932; age 60; died July 23, 1968. Dr. Vogel was on the staffs of Fitzgerald Mercy, Bryn Mawr and Delaware County Memorial hospitals.

From 1942 to 1962 he was chief of pediatrics at Fitzgerald Mercy. Survivors include his wife, a son, a grandson and a sister.

John A. Cottam, Pittsburgh; University of Toronto School of Medicine, 1908; age 79; died May 10, 1968. We have received no information regarding survivors.

Joseph A. DeMatteo, Malvern; Hahnemann Medical College, 1960; age 34; died August 16, 1968. Dr. DeMatteo was medical director of the Western Electric Co., Inc. plant at King of Prussia. He was a member of the Industrial Medical Association. Surviving are his wife, four daughters, two sons, his parents and a sister.

⊙ **John A. Daugherty**, Harrisburg; Jefferson Medical College, 1929; age 66; died August 28, 1968. Dr. Daugherty was former chief of staff of the Harrisburg Hospital, a Fellow of the American College of Physicians, a past president and chairman of the Pennsylvania Blue Shield board and a member of the American College of Chest Physicians of Philadelphia. He is survived by his wife, three sons, a sister, a brother, and eight grandchildren.

⊙ **Joseph Aaronoff**, St. Petersburg, Florida; Jefferson Medical College, 1912; age 82; died June 10, 1968. We have received no information regarding survivors.

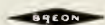
⊙ **Frank C. Boucek**, Miami, Florida; University of Pittsburgh School of Medicine, 1908; age 82; died August 16, 1968. Survivors include his wife, two sons, a daughter, thirteen grandchildren and three great-grandchildren.

⊙ **Archer P. Crosley, Jr.**, Philadelphia; University of Pennsylvania School of Medicine, 1945; age 47; died August 21, 1968. Dr. Crosley was director of clinical pharmacology for Smith Kline and French Laboratories and acting director of research at the Research Institute of Presbyterian-University of Pennsylvania Medical Center. Surviving are his wife, two daughters, a son and his father.

*Easy on
the Budget...*

*Easy on
the Mother*

*NN Tablets & Elixir NN
For Iron Deficiency Anemia*



BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS
Fergon[®]
brand of FERROUS GLUCONATE



Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

EASTERN PENNSYLVANIA OFFICE:

E. L. Edwards, D. R. Lowe, L. R. Wilson, Jr., and S. B. Elston, Jr., Representatives
Suite 126-BC, The Benson, Jenkintown 19046 Telephone: 215-887-6335

WESTERN PENNSYLVANIA OFFICE: N. Wells and S. T. Ingram, Representatives
1074 Greentree Road, Pittsburgh 15220 Telephone: 412-531-4226



PHYSICIANS WANTED

Psychiatric Residencies—Norristown State Hospital. First, second and third year openings available in modern, dynamic training center with broad eclectic program which includes comprehensive community psychiatry, forensic, alcoholic, group and family treatment, geriatric, adolescent, adult, acute, day and night treatment centers. Medical school affiliations and others for psychophysiological psychiatry and intensive individual child adolescent and adult out-patient therapy, psychoanalytical oriented, thirty minutes from cultural Philadelphia; beautiful progressive suburban area, unlimited opportunities for practice. Housing and maintenance available. Salaries for licensed physicians begin \$10,954; unlicensed \$8,580. Call or write **DIRECTOR OF TRAINING AND EDUCATION**, Norristown State Hospital, Norristown, Pa. (215) 275-9700.

Needed—Staff physicians, internists and generalists: JCAH fully accredited ultra-modern 2000-bed chronic disease hospital (no psychotic or tuberculous patients); dynamic rehabilitation program; university affiliations; regular consultation available in all specialties; 5 day 35 hour work week; liberal paid vacations and holidays; pension plan; insurance and other fringe benefits; limited number of ranch type homes and apartments available on the premises; Pennsylvania license required; salary competitive and negotiable. Contact **G. P. HAMMILL, M.D.**, John

J. Kane Hospital, Pittsburgh, Pa. 15243.

Associate Radiologist—Board Certified or qualified, to be member of a three man group. General community hospital in southwestern Pennsylvania. Liberal income. Write Department 531, PENNSYLVANIA MEDICINE.

Psychiatric residency training—2 year approved, third year in University connected Psychiatric Institute. \$8,580 to \$12,075; maintenance arrangements possible. ECFMG and/or license acceptable in Pennsylvania required. **R. L. GATSKI, M.D.**, Superintendent, Danville State Hospital, Danville, Pa. 17821.

Wanted: Two radiologists for progressive x-ray department in a 325-bed general hospital in western Pennsylvania. Equipment excellent, including 2 remote TV units. At least one applicant must be board certified. Many fine strictly residential areas within 10 minutes of hospital. Relations with administration excellent. All compensation negotiable. Personal interviews required. Need is immediate, but can await previous commitments. Send resume to Department 532, PENNSYLVANIA MEDICINE.

Approved one year rotating internship—available January 1, 1969, in 301-bed general hospital; Philadelphia suburb; ECFMG Permanent Certification required of foreign graduates; Exchange Visitor Number available; \$500 per month and full maintenance or

extra living-out allowance; duty every 3rd night and 3rd weekend; active teaching and resident training program. Apply: **DIRECTOR OF MEDICAL EDUCATION**, Delaware County Memorial Hospital, Drexel Hill, Pa. 19026.

Straight surgical internship available in 300-bed community hospital in Center-City Philadelphia. Program—General, thoracic and all sub-specialties of surgery. Participate in active teaching program. ECFMG required. Contact **DR. CHARLES FINEBERG**, Director of Surgery, Samuel H. Daroff Division, Albert Einstein Medical Center, 5th and Reed Streets, Philadelphia, Pa. 19147.

Industrial physician, full time, for large chemical plant in southern New Jersey across the Delaware River from Wilmington, Delaware. Duties will include pre and post-employment physical examinations, treating illnesses and injuries, toxicological problems, and overseeing health of 7,200 employees. Medical staff includes six full-time physicians, complete plant hospital, fully equipped laboratory with nine nurses and adequate laboratory staff. Excellent opportunity. Good starting salary plus excellent employee benefits. Pleasant surroundings. Relocation expenses paid. An equal opportunity employer. Write Department 533, PENNSYLVANIA MEDICINE.

Anesthesiologist—Board eligible or certified. Developing department in expanding 185-bed specialty hospital of University Health Center group. Teaching and research opportunities. Salary negotiable. Call or write: **J. R. QUINN, M.D.**, Eye and Ear Hospital, Pittsburgh, Pa. 15213.

Internist: Prefer individual who can work 40 hr. five day week. Pennsylvania license required. Salary to \$27,000.00 per annum depending upon qualifications. Contact: **THE MEDICAL DIRECTOR**, All Saints' Hospital, Philadelphia, Pa. 19118.

Physicians—Part or full time. Student and employee health service. Medical School hospital affiliation. Faculty appointment. Salary commensurate with qualifications. Submit curriculum vitae. Z-29, P. O. Box 2069, Philadelphia, Pa. 19103. An equal opportunity employer.

CLASSIFIED ADVERTISING INFORMATION

RATES—\$10.00 per insertion up to 30 words; 40 cents each additional word; \$1.00 per insertion for answers sent in care of Pennsylvania Medical Society. Payable in advance.

COPY DEADLINE—Copy due by the first day of month preceding month of publication. Send to Pennsylvania Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pennsylvania 17043. The right is reserved to reject or modify copy to conform with publication rules.

DEPARTMENT NUMBERS—Advertisers using department numbers forbid disclosure of their identity. Written inquiries are forwarded to such advertisers.

WORD COUNT—Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one, and "Write Department . . . , Pennsylvania Medicine," as five.

General Practitioners: We Need You. Beautiful, progressive community of Zelienople, located just 30 minutes north of Pittsburgh. Market area of 10,000. Excellent facilities, Assistance available. T. R. MURRAY, Zelienople Area Jaycees, Box 35, Zelienople 16063.

Approved two year general practice residency—available January 1, 1969, in 301-bed general hospital; Philadelphia suburb; one year approved internship required; ECFMG certificate required of foreign graduates; Exchange Visitor Number Available; \$600 per month and full maintenance or extra living-out allowance; duty every 4th night and 4th weekend; active teaching program and approved internship. Apply: DIRECTOR OF MEDICAL EDUCATION, Delaware County Memorial Hospital, Drexel Hill, Pa. 19026.

Opportunity for G.P., surgeon, internist with Pennsylvania license in town of 5,000 in northwest Pennsylvania. Office, equipment and staff privileges available to qualified physician. Contact ADMINISTRATOR, Kane Summit Hospital, Kane, Pa. 16735.

Attractive opening with The Pennsylvania State University for qualified psychiatrist interested in challenge of increased need for expansion of services to University undergraduate and graduate students. Dynamic progressive program. Opportunity for teaching experience. Many liberal benefits, including educational privileges for your family. Healthful mountain community with excellent hunting, fishing, camping, and other recreational facilities. For more information, contact: JOHN A. HARGLEROD, M.D., Director, University Health Services, Ritenour Health Center, University Park, Pa. 16802. An Equal Opportunity Employer.

Psychiatrist or physician—accredited hospital. Approved psychiatric residency program, affiliated with approved general hospital. \$14,657 to \$22,768; maintenance arrangements possible. Pennsylvania license required. R. L. GATSKI, M.D., Superintendent, State Hospital, Danville, Pa.

Associate—General practitioner, young, to join two general practitioners in central Pennsylvania. Modern office, good hospital facilities. Salary first year then partnership. No expenses. Write Department 526, PENNSYLVANIA MEDICINE.

Emergency Room physicians needed for full-time staffing. Ideal for the new graduate or for the experienced physician wishing to slow down. Write ADMINISTRATOR, Sharon General Hospital, Sharon, Pa.

Physician for Student Health Service. Easy hours, pleasant work, excellent fringe benefits. Contact H. C. PIEPER, M.D., Director, University Health Service, Lehigh University, Bethlehem, Pa. 18015. An equal opportunity employer.

House physician for 202-bed general hospital, located in a growing university community, 55 miles from Pittsburgh. Rotate services with other house physicians. Pennsylvania license required. An excellent introduction to a community with good practice opportunities. Contact ADMINISTRATOR, Indiana Hospital, Indiana, Pa. 15701.

Wanted: Full time industrial physicians for permanent employment in du Pont Company plants in various states. Career positions. Excellent opportunity. General practitioners preferred. Salary open. Immediate openings. An equal opportunity employer—male/female. Call collect or write to: C. A. d' ALONZO, M.D., Medical Director, E. I. du Pont de Nemours and Company, 11400 Nemours Building, Wilmington, Delaware 19898, (302) 774-6234.

Internists, general practitioners, radiologists wanted to group medical practice in inter-city Philadelphia. Prefer those interested in social change. Competitive salary, fringe benefits and faculty appointment to medical school for qualified physicians. Please contact DR. HALE COOK, 3450 North 17th Street, Philadelphia, Pa. 19140.

Cardiologist—To be available immediately, Charleroi-Monessen Hospital, North Charleroi, Pa., 15022. Must be Board certified or Board eligible in cardiology, or must be Board certified or Board eligible in internal medicine with at least one additional year of formal training in cardiology. Primary duties to serve as chief of the department of cardiology and director of the coronary intensive care unit presently under development. Hospital consists of 211 beds plus 24 bassinets and is in a developmental expansion program. The present volume of electrocardiograms is 4,500 per year. Terms open. The hospital will defray up to ½ the

expense for personal interview. Direct all responses to the Administrator.

PRACTICES AVAILABLE

General Practice—for sale, Central Bucks County, Pa., active, acute, no OB, good coverage, open staffed hospitals, excellent gross, will introduce, inquiries invited. DANIEL A. NESI, M.D., 202 N. Main St., Chalfont, Pa. 18914.

Practice available due to death of physician. Thirty-seven year old practice in internal medicine, more than 3,000 active patients. Serving entire South Hills area of Pittsburgh. Well-appointed office. Receptionist and answering service maintaining continuity. Contact Mrs. David Weisberg, 6648 Nicholson St., Pittsburgh, Pa. 15217. Telephone (412) 521-5714.

OFFICES AVAILABLE

General Practitioners—Rent-free air conditioned offices for first year. Centrally located with adequate parking. Beautiful resort area in southcentral Pennsylvania. Bedford offers an excellent practice opportunity. Small town; friendly surroundings with no big city problems. Write giving all particulars to P.O. Box 162; Bedford, Pa. 15522.

FOR SALE

Nursing Home-Extended Care Facility (Medicare)—30 years, fine reputation. Competent staff. Acreage for easy expansion. Beds filled constantly. Waiting list. Asking price for a quick sale; retiring. Write Department 534, PENNSYLVANIA MEDICINE.

OFFICE SPACE AVAILABLE

Established doctor's office for rent: 1315 Derry Street, Harrisburg, Pa. 17104. Front and rear entrance, air conditioned, garage in rear, entire first floor; light, heat and water furnished. Contact EDWARD C. ALLEN, (717) 238-3187.

For sale or lease: Fully equipped office in Allentown, Pa. Location excellent for GP or specialist. City has two large opened staffed hospitals, office available immediately. Phone (215) 422-3761.



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®. Glyceril guaiacolate, 50 mg, Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A-H ROBINS



**PENNSYLVANIA
MEDICINE**

write now

Booklets: *An Environment Fit for People*, 25¢ from Public Affairs Committee, Inc., 381 Park Avenue South, New York, N.Y. 10016. . . *Occupational Therapy—A New Life for the Disabled*, 25¢ from Public Affairs Committee, Inc., 381 Park Avenue South, New York, N.Y. 10016. . . *SKF Services Catalog 68-69*, gratis from Smith Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia, Pa. 19101.

Pamphlets: *Why Not Be a Medical Technologist?*, 10¢ from the U. S. Government Printing Office, Washington, D.C. 20402. . . *Classification and Management of Diabetes Mellitus for the Physician*, free from Diabetes Detection Program, 342 Madison Avenue, New York, N.Y. 10017. . . *Narcotics: Some Questions and Answers*, *Marihuana, Some Questions and Answers*, and *The Up-and-Down Drugs: Barbiturates and Amphetamines*, each 5¢ per copy or \$3.25 per hundred, from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. . . *American College of Radiology Catalogue of Materials*, available from the Commission of Public Relations, American College of Radiology, 20 North Wacker Drive, Chicago, Illinois 60606.

Film: *Insertion and Removal of an Intra-Uterine Device (IUD)*, from the University of Washington Press, Seattle, Washington 98105, \$90.00 including cartridge.

Northeastern Proctologic Conference

Meeting November 10-17

Runaway Bay Country Club and Hotel

Jamaica, B.W.I.

Under the Auspices of the New England

Proctologic Society

Those Participating Include

New England Proctologic Society

New York Society of Colon and Rectal Surgeons

New Jersey Proctologic Society

Pennsylvania Society of Colon and Rectal Surgery

PROGRAM CHAIRMAN

BERNARD J. KAPLAN, M.D.

21 Woodland Street,

Hartford, Connecticut 06105

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?

or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST

(Rosenthal)

The **LEDERTINE™** Applicator with the **Blue Handle**

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).



Ask your representative for details or write Medical Advisory Dept.,
Lederle Laboratories, Pearl River, New York 10965. 406-8



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity¹ or side effects^{2,3} and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. 38:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. 20:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

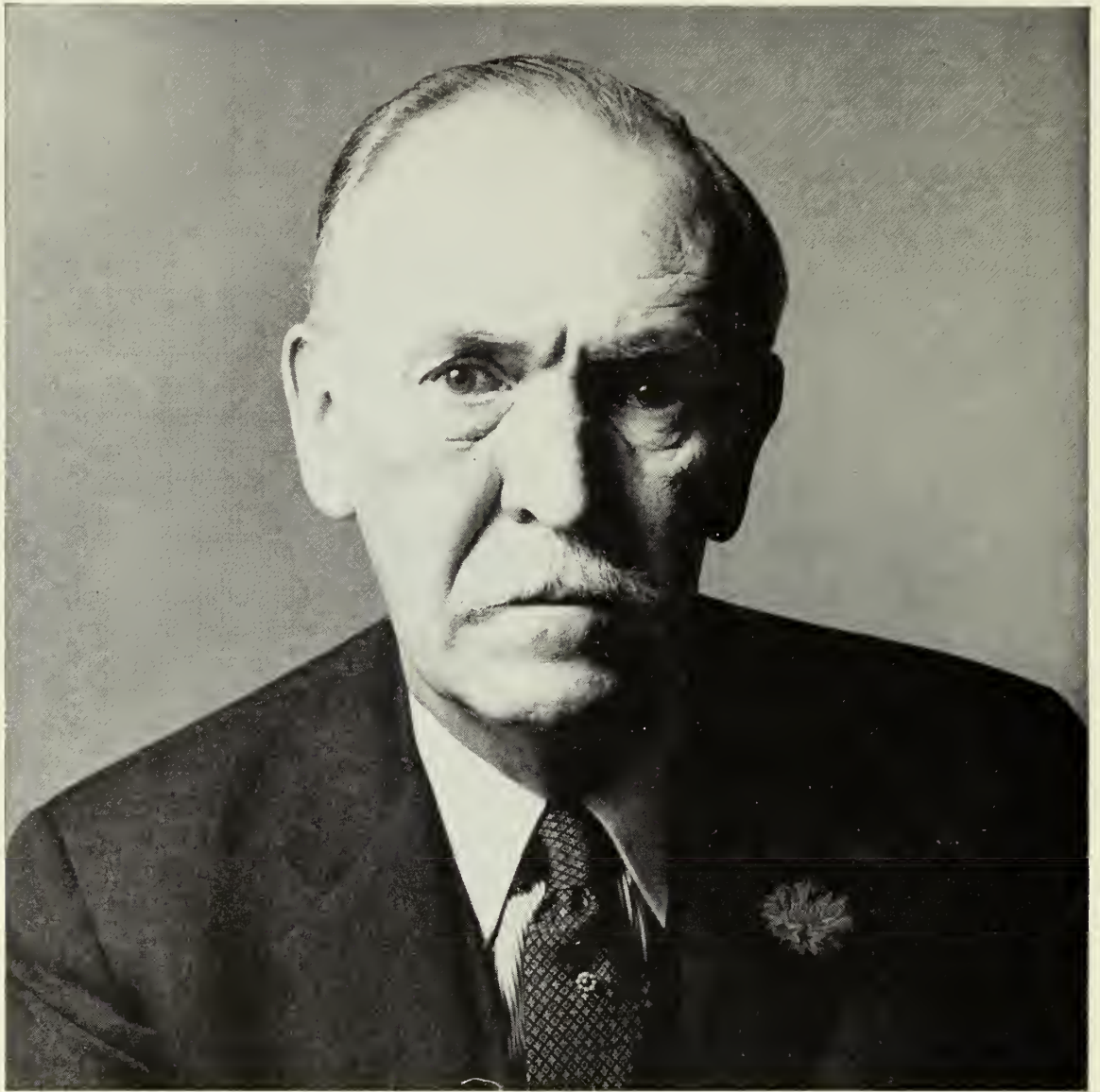
Emetrol[®]
phosphorated carbohydrate
solution
emesis control



"COKE HAS THE TASTE YOU NEVER GET TIRED OF."



Help the Needy!



A patient of advancing years may appear to “have everything,” but may well be in need—*medically*. You know the symptoms. He’s tired most of the time. Though there’s nothing wrong with him organically, he suffers from general malaise. Lassitude has become his way of life . . . vague aches and pains his major concern.

Such a patient has entered the “Mediatric Age”—that stage of his life in which he’s an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support he’s apt to need. MEDIATRIC is intended to help keep him more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition

to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal

bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—
		(Contains 15% alcohol†) ‡Some Loss Unavoidable

Mediatric® tablets • capsules • liquid

Steroid-nutritional compound



AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada

6838



in my opinion Hershey Revisited

Recently I was privileged to tour the facilities of the new Penn State Medical Center at Hershey. This tremendous addition to central Pennsylvania has been brought about by a combination of a great amount of money and remarkable ingenuity and know-how.

The tour was a source of fascination. It was apparent that the kind of education the students will receive in this new institution is very different from that of the ante-diluvian times that I remember. The study cubicles, the multi-disciplinary laboratories, and the arrangements for animal experimentation need to be seen to be appreciated. The value of the tour was heightened considerably by students who were situated at key points. They were most capable at answering the many questions that arise in the mind of an old doctor. Outstanding physical facilities are all very well but we should be aware that their value is negligible if they are not used by inquiring minds with good direction. The curriculum, if it can be called that, which the students of today are experiencing represents the most revolutionary part of the effect that Hershey will have on medicine in the years to come. The first year students are at present like other Penn State students in their third trimester. They have already had some formal training in anatomy, physiology, and bio-chemistry. But now and for the rest of the school term, they have formal scheduled classes only on Monday in a broad subject entitled "Biological Science." The remainder of each student's week is taken up with electives and research projects. Some of the projects are in familiar fields and involve the laboratories and animal pens which are so innovative. We also learned that many of them are doing research in the social sciences and humanities. Animal behavior is an important

concern and one student is actually turning out research which involves his teaching a class in Harrisburg.

These new approaches to education seem revolutionary, but thinking people for some time have realized that something very different is called for in the preparation of physicians in a changing world. Scarcely had I returned home from Hershey when the newspapers announced that the University of Pennsylvania is radically altering its program with a tremendous increase in the amount of elective time. I cannot but believe that these changes must produce doctors who are more thoughtful and better prepared to practice under conditions where the only constant is variation.

The countless avid readers of this publication are well aware that the editorial policy is directed toward the preservation of something approximating today's general practitioner, a physician who is patient, not disease or organ, oriented. My first feelings on considering the trend to elective programs was a fear that these elections would go against my party.

I am a great believer in the inevitable victory of virtue. Given a free system of choice, the best will ultimately prevail. If, as I believe, medicine cannot adequately serve humanity without a large central core of doctors who have a broad-based approach then the doctors of the future will in some way or other fulfill this need. There may be obstacles in the path but the eventual outcome is sure. Among its many innovations Hershey has on its faculty full-time family doctors in contact with the medical student. The opportunity for choice is there. Hope is high.

GEORGE A. ROWLAND, M.D.
Millville

Advertiser's Index

Abhoff Laboratories	30, 31, 32
Ayerst Laboratories	116, 117
Bertholon-Rowland Agencies	63
Breon Laboratories	111
The Brown Pharmaceutical Co.	106
Burroughs-Wellcome	37
Coca Cola Company	115
Conal Pharmaceuticals, Inc.	119, 120
The Dow Chemical Company	43
Geigy Pharmaceuticals	4, 5, 6, 38, 39, 40, 41, 42, 64, 65, 66
Glenbrook Laboratories	58
Hynson, Wescott & Dunning	1
International Pharmaceutical Corp.	34, 35
Lederle Laboratories	3, 17, 18, 19, 20, 51, 57, 114
Lilly, Eli and Company	46, 47, 48, 60, 61, 84, 101
Loma Linda Foods	78
Medical Protective Co.	111
Merck, Sharp & Dohme	98
The National Drug Co.	33

Ohetrol Pharmaceuticals	25
Parke, Davis & Company	21, 79
Pennsylvania Society for Colon and Rectal Surgery	114
Pitman-Moore	14, 15
Poythress, Wm. P. & Co., Inc.	22
Robins, A. H. Co., Inc.	59, 82, 114, 121, 122, 3rd Cover
Roche Laboratories	29, 4th Cover
Rocrig, J. B. & Company	108, 109
Rorer, Wm. H., Inc.	24, 115
Sandoz Pharmaceuticals	100
Searle, G. D. & Co.	80, 81
Smith Kline & French Laboratories	77
Strassenburgh Pharmaceuticals	99
The Stuart Company	62
Vale Chemical Company	23
Warner Chilcott Laboratories	36
Wetherhold and Metzger	16
Winthrop Laboratories	102



when relief
means so much
in keeping
your G.U.
patient comfortable

URISED[®]

 **CONAL**
PHARMACEUTICALS, INC.

Clinically effective for *G.U. Therapy*¹⁻⁵

There are not many drug combinations in use today which can claim to have served the medical profession for more than 50 years. Such a record reflects the continued confidence of physicians in URISED. This is not a dramatic "wonder drug"—but a useful one.

It fills a need in urologic and general practice—a need for a mild but reliable agent with a very low order of toxicity. It can be used alone to treat mild and uncomplicated urinary infections. It can be used as "interim therapy" while awaiting the results of urine culture. It can be used as an adjunct (to relieve pain and spasm) with almost any other form of anti-bacterial therapy.

The characteristic blue/green urine tells the patient that something is happening. The patient generally tells you that symptomatic relief follows the first dose.

REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32, 1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

URISED®

Each Blue-Coated Tablet contains Active:

Atropine Sulfate 0.03 mg.	Methylene Blue . . 5.4 mg.
Hyoscyamine . . 0.03 mg.	Phenyl Salicylate 18.1 mg.
Methenamine . . 40.8 mg.	Benzoic Acid . . . 4.5 mg.

PRECAUTIONS: Administer with caution to persons with atropine idiosyncrasy or cardiac disease.

SIDE EFFECTS: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

(Stocked Nationally Through All Service Wholesale Druggists)



CONAL
PHARMACEUTICALS, INC.
CHICAGO, ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

ANESTACON™ • CYSTOSPAZ® • MANDACON™ • URISED®
URISEDAMINE® • ŪTRASUL® Tablets and Suspension



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN®



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"

ROBITUSSIN®

Each 5 cc. contains:

Glyceryl guaiacolate 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs

ROBITUSSIN® A-C

Each 5 cc. contains:

Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control

ROBITUSSIN® DM

Each 5 cc. contains:

Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide . . 15.0 mg.
Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough

ROBITUSSIN® PE

Each 5 cc. contains:

Glyceryl guaiacolate 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HANQ

A. H. Robins Company, Richmond, Va. 23220

A-H-ROBINS

*ready
for bed..*



*but not
for
sleep*

**...because psychic tension
may not stop at night**

The calming action of Valium (diazepam) helps counteract psychic tension and reduce overreaction to stresses during the day. Often the t.i.d. dosage schedule is enough to prevent build-up of tenseness that may interfere with sleep at night.

However, when psychic tension does contribute to sleeplessness, Valium can be especially useful. A tablet at bedtime, added to the daytime t.i.d. dosage, can help your patient be ready for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely

depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium[®]
(diazepam)



Roche[®]
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PENNSYLVANIA MEDICINE

THE FRANCIS & TAYLOR
LIBRARY OF MEDICINE
BOSTON

NOVEMBER 1968

13 NOV 1968



Human Heart Transplantation

X EXCHANGE PRICE
FRANCIS & TAYLOR LIB
MED-10 SHATTUCK ST
BOSTON MASS 02115

ILITY



THE PHYSICIAN'S BUSINESS

For the motivation of a maturing generation seeking rewarding, lifetime pursuits in the health care industry where they can contribute toward man's well being, the

Premiere

of a semi-documentary film emphasizing the unexcelled opportunities awaiting young men and women in more than 200 fascinating, productive careers in medicine and allied fields.

The 28-minute, 16mm color film dramatizes that there's a place for every qualified student in the health field. For those who have the compulsion to mend a broken body . . . the compassion to salve a tormented mind . . . or the imagination to seek the secrets of life in a single drop of blood . . . there are



Horizons Unlimited

HELP FILL THE MANPOWER DEMAND BY SUPPORTING



**MEDICAL STUDENT RECRUITMENT PROGRAM
OF THE PENNSYLVANIA MEDICAL SOCIETY
MEDICAL EXPLORER PROGRAMS OF THE BOY
SCOUTS OF AMERICA.**

"Horizons Unlimited" is recommended for high schools, colleges, medical societies, hospitals, television stations, auxiliaries, health career councils, youth organizations and other appropriate groups. Write to the P.M.S. Council on Public Service for film loan information and recruitment program details.



PENNSYLVANIA
MEDICINE

THE FRANCIS & TAYLOR
LIBRARY OF MEDICINE
BOSTON

13 NOV 1968

/medigram

NOVEMBER, 1968

DR. HARER DIES; '62 PRESIDENT

W. Benson Harer, M.D., of Upper Darby, President of the Pennsylvania Medical Society in 1962-63 and one of its most active members, died October 11 at Fitzgerald-Mercy Hospital. He was 71 years old and was Director of Medical Affairs for Blue Cross of Philadelphia for the past several years. For 15 years he served in dozens of capacities with the Delaware County Medical Society, the State Society and the American Medical Association. He served as Vice-Chairman of the Pennsylvania Delegation to the AMA and participated in the 1968 annual session in San Francisco in June. Some of his State Society service included work with the Officers' Conference Committee, the Committee on Aid to Education, the Committee to Study Relationships Between Medicine and Osteopathy, the Labor-Medicine Liaison Committee and the Committee on Objectives. He served as a member of the Board of Trustees and Councilors from 1955 to 1962. He was a civic leader as well as a medical leader and was the author of three textbooks on obstetrics and gynecology. He is survived by his wife, the former Letitia Burke; a son, W. Benson Harer, Jr., M.D.; a daughter, Mrs. Marian Fetterman; eight grandchildren and a brother.

OFFICERS' CONFERENCE SET

The 1969 State Society Officers' Conference Committee is holding meetings to establish the program and format for the annual spring meeting to be held in Harrisburg in April.

MEDICAL EXAMINER ACTION

The State Society Council on Governmental Relations has obtained professional assistance in drafting legislation which would establish a medical examiner system in Pennsylvania. Such legislation ultimately will be introduced in the General Assembly as a result of the Constitutional revision which eliminated the office of the coroner as a mandated office.

TV PILOT STUDY APPROVED

The State Society Council on Education and Science has been authorized to obtain a special group of consultants to explore television engineering feasibilities and programs to satisfy medical education needs and the Council has been further authorized to solicit funds from any sources interested in underwriting such a pilot study. The recommendation, and ultimate Board approval, grew out of an exploratory meeting held by the Council several months ago.

RUSH AWARD FORUM CHANGED

The forum for the presentation of the State Benjamin Rush Awards has been changed from the Officers' Conference to the State Dinner Program, effective in 1969. The change was proposed by the Council on Public Service to underscore the importance of the awards. The deadline for the receipt of county society nominations remains the same-- Feb. 1st

FEDERAL MEDICAL SCHOOL

One of the first items for the next session of Congress will be a renewed proposal for the establishment of a federal medical school, military oriented, near Washington. Despite the Congressional proposal, the Defense Department does not favor the construction of new facilities and prefers some sort of contractual arrangements with existing medical schools.

ANTI-VIRAL PROMOTION HIT

Statements by the manufacturer suggesting the use of the anti-viral chemical, amantadine hydrochloride, as an anti-flu measure resulted in the Public Health Service saying that it does not consider the drug to be a useful public health measure against flu. The FDA has told the manufacturer to modify its promotional statement.

CHOLESTEROL TARGET AGAIN

The American Heart Association is working on a new statement underscoring its earlier position on the relationship of serum cholesterol and heart disease. The statement is expected to use the strongest language ever in recommending the use of polyunsaturated fats in food as a means of lowering serum cholesterol levels.

NATIONAL FAMILY HEALTH WEEK

President Johnson has signed the joint House/Senate Resolution designating November 17-23 as National Family Health Week. The resolution, requested by the American Academy of General Practice, proclaims the week "as a means of focusing national attention during the year upon the accomplishments of the American health care system and the central role played by the family physician in the maintenance of superior medical care for Americans of all ages and from all walks of life." According to the AAGP, the health week offers Americans an opportunity to examine their health care system and the role played in it by their family doctor.

DIABETES WEEK SET

The American Diabetes Association, with the cooperation of a number of state and county medical societies, has established November 17-23 as Diabetes Detection Week in an effort to uncover at least some of the estimated 1.5 million persons in the nation with undiagnosed diabetes. Information and materials for Detection Week observance are available from the Association at 18 East 48th Street, New York, N.Y. 10017.

Lutrexin[®]

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

**IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF
PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION**

LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.

Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

■ Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting
uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC.



BALTIMORE, MARYLAND 21201

(LUTREX)

PENNSYLVANIA MEDICINE®

© 1968 Pennsylvania Medical Society

The Pennsylvania Medical Journal
Official Publication of the Pennsylvania Medical Society

NOVEMBER, 1968

VOLUME 71, NUMBER 11

ORIGINAL PAPERS

Rehabilitation of the Cancer Patient	53
Human Heart Transplantation	57

FEATURES

Extended Medical Care Facilities	66
The Physician's Business	73

NEWSFRONTS

M.D.s Stage Fly-in	7
Pennsylvania Medical Golf Awards	8
Health Officials Deny Double Payment Charges	9
Lancaster Physician Visits Soviet Counterparts	10
P.M.S. Woman's Auxiliary Annual Convention	24
Closeup/M.D.s	28
Capitol Report	44

EDITORIALS

Immunizing Against Influenza	49
The High Cost of Medical Care	50

SCIENTIFIC REPORTS

Cardiovascular Briefs	80
Cancer Forum	89

GENERAL

Continuing Education	86
Meetings	90
Obituaries	92
Classified	94
Write Now	97
In My Opinion	100
Advertiser's Index	100

PUBLISHED MONTHLY BY THE
PENNSYLVANIA MEDICAL SOCIETY
TAYLOR BYPASS AND ERFORD ROAD,
LEMOYNE, PENNSYLVANIA 17043

Subscription \$5.00 Single Copy 50¢

PUBLICATION COMMITTEE

H. Thompson Dale, M. D., State College,
Chairman
D. George Bloom, M.D., Johnstown
William J. Kelly, M.D., Pittsburgh
Robert S. Sanford, M.D., Mansfield
Ralph K. Shields, M. D., Bethlehem

STAFF

Carl B. Lechner, M.D., 4111 Beech Avenue,
Erie 16508—Medical Editor
David A. Smith, M.D., Polyclinic Hospital,
Harrisburg 17105—Associate Medical
Editor
Thomas J. McCaghren, Taylor Bypass and
Erford Road, Lemoyne 17043—Man-
aging Editor
Mary L. Uehlein, Taylor Bypass and Er-
ford Road, Lemoyne 17043—Editorial
Assistant

CONTRIBUTING EDITORS

Harry E. Bacon, M.D., Philadelphia
William C. Beck, M.D., Sayre
Walter I. Buchert, M.D., Danville
Lewis T. Buckman, M.D., Wilkes-Barre
A. Reynolds Crane, M.D., Philadelphia
Garfield G. Duncan, M.D., Philadelphia
Mario N. Fabi, M.D., Scranton
George H. Fetterman, M.D., Pittsburgh
Wendell B. Gordon, M.D., Pittsburgh
Samuel B. Hadden, M.D., Philadelphia
Jack D. Myers, M.D., Pittsburgh
William Likoff, M.D., Philadelphia
Eugene P. Pendergrass, M.D., Philadelphia
Mary DeWitt Pettit, M.D., Philadelphia
Sydney E. Sinclair, M.D., Camp Hill
David A. Smith, M.D., Harrisburg
James R. Watson, M.D., Pittsburgh

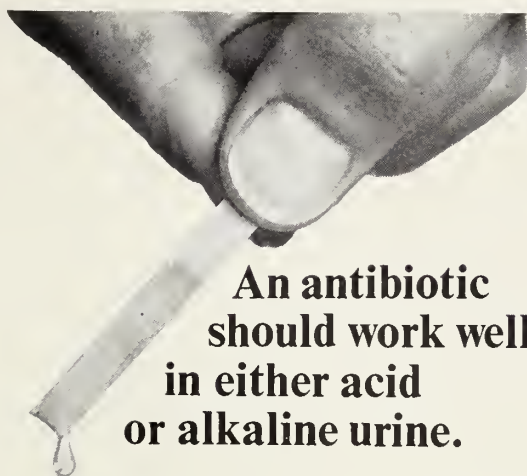
• **GENERAL.** Established 1897. Penn-
sylvania Medicine may not be held re-
sponsible for opinions expressed in any
of its contents.

• **EDITORIAL.** Address all original
papers, features, and editorial corre-
spondence to the Managing Editor.

• **ADVERTISING.** Pennsylvania Medi-
cine's advertising policy conforms with
principles governing advertising in
American Medical Association scientific
publications. National advertising rep-
resentatives: State Medical Journal Ad-
vertising Bureau, Inc., 510 North Dear-
born Street, Chicago, Illinois 60610.
Advertising rates on request to Penn-
sylvania Medicine office, Taylor Bypass
and Erford Road, Lemoyne, Pennsylvania
17043, or the SMJAB. For classified
rates, see classified section.

• **MAILING.** Second-class postage paid
at Lemoyne, Pennsylvania.

• **CHANGE OF ADDRESS.** Give name,
old address, new address (include ZIP
number), state if change is permanent
or temporary. Send notice to Pennsylv-
ania Medicine, Taylor Bypass and Er-
ford Road, Lemoyne, Pennsylvania
17043. Allow six weeks for change of
address.



**An antibiotic
should work well
in either acid
or alkaline urine.**

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system — anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin — maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney — rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated — 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-B

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Do you have patients who try to hide frustration behind conformity?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you.

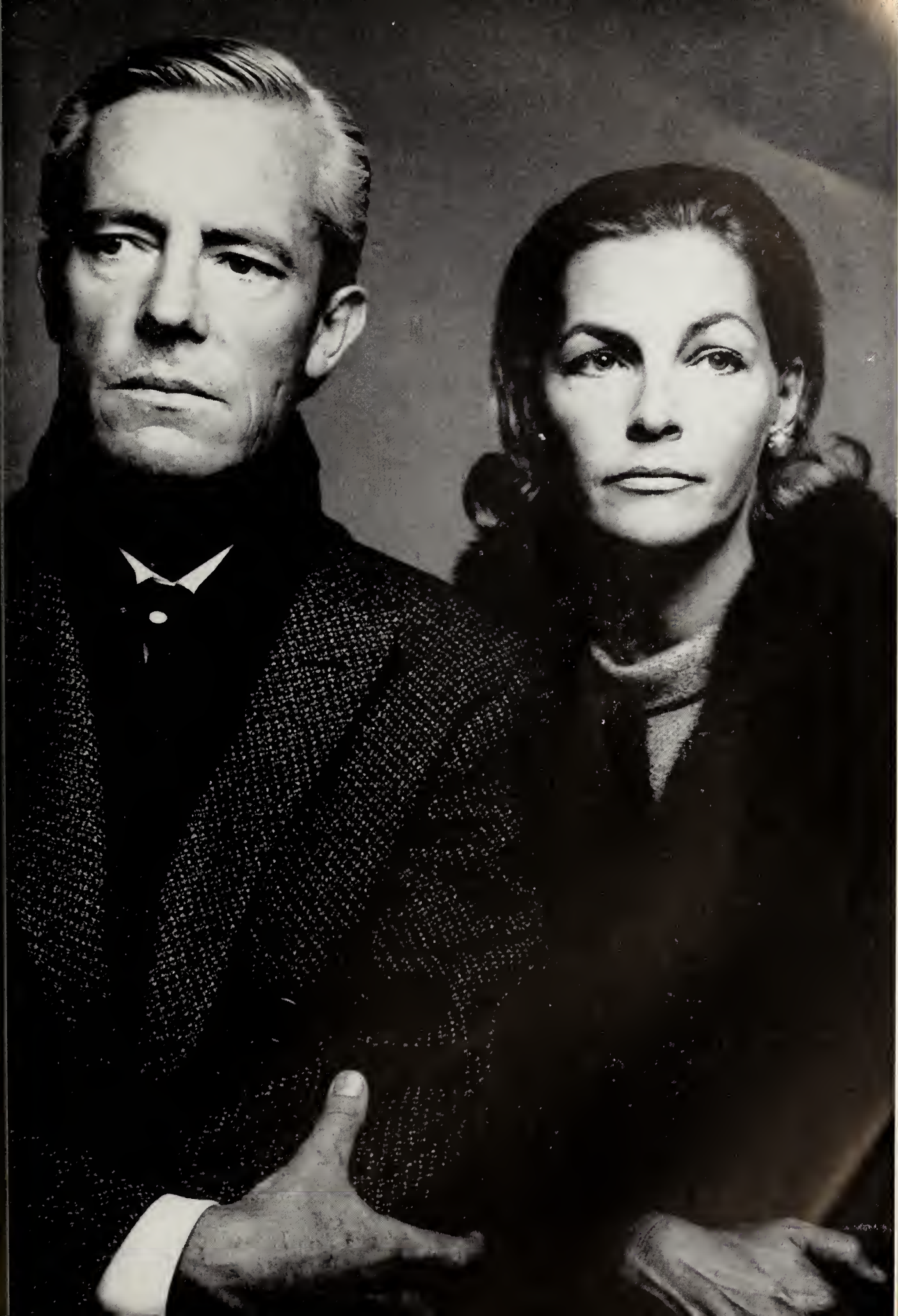
Whether depression is open or secretive, Aventyl HCl assists in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.

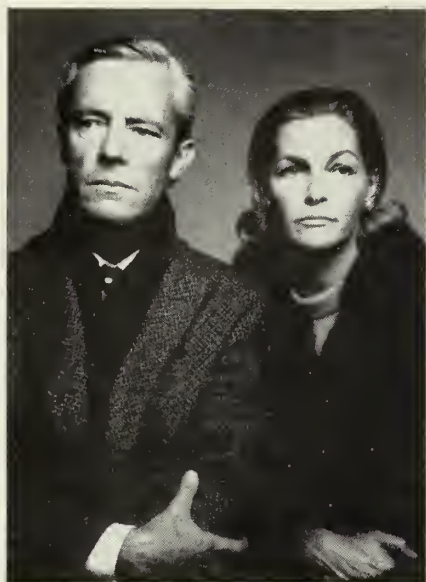


Eli Lilly and Company
Indianapolis
Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline Hydrochloride





Aventyl® HCl

Nortriptyline Hydrochloride

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two months after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic pur-

pura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl® HCl (nortriptyline hydrochloride, Lilly) under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily

10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily

10 mg.—Ages three to six, 1 Pulvule one to three times daily

Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily

Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500.

Additional information available to physicians upon request.

Lilly

Eli Lilly and Company
Indianapolis
Indiana 46206



newsfronts



Round Table Panel—Pennsylvania flying physicians attending the FPA Annual Meeting at Tan-Tar-A join other members in a discussion on Maximum Aircraft Performance. Left to right: William G. Thompson, M.D., Pittsburgh; Richard S. Clover, M.D., Lemar; Leon P. Scicchitano, M.D., Pottsville; Robert A. Winstanley, M.D., Johnstown; Joseph E. Michaud, M.D., Johnstown; Harold H. Meanor, Jr., M.D., Sewickley; and guest Thomas E. Eilderton, D.D.S., Sewickley.

F.P.A. Annual Meeting

M.D.s Stage Fly-In

A group of Pennsylvania flying physicians joined doctor-pilots from all over the country in transforming a quiet, rural Missouri airstrip into a bustling scene rivaling O'Hare Field or John F. Kennedy International Airport.

The doctors are members of the Flying Physicians Association, an international group dedicated to promoting general aviation safety through example and teaching. They gathered at Tan-Tar-A at the Lake of the Ozarks to hold their 14th Annual Meeting.

For five days, they participated in round table discussions and heard addresses by leading authorities in aviation safety and aerospace medicine.

Founded in 1954 by a handful of doctors, the FPA has grown in leaps

and bounds. Today, the organization has some 2,000 members, is international in character, and has a permanent headquarters at 332 South Michigan Avenue in Chicago.

There are 75 FPA members in Pennsylvania. Robert A. Winstanley, M.D., of Johnstown serves as a vice-president of the national organization.

Every state is represented in the FPA and members reside in Canada, Mexico, Puerto Rico, South America, the West Indies, Australia, West Germany and the Republic of the Congo.

"It's the members' mutual interest in medicine and aviation that makes the organization so strong," remarked Richard S. Clover, M.D., of Lemar, Pa.

Doctor Clover heads the association's important Safety Committee.

In addition to encouraging safe flying, his committee is frequently called upon to evaluate new safety and survival equipment, not only for the FPA but for general aviation.

During the scientific program at Tan-Tar-A, the FPA'ers heard from experts such as: Thomas J. Price, Executive Vice-President, Flight Safety Foundation; Captain Richard Stone, Airline Pilots Association; Richard L. Collins, editor, Air Facts magazine; and Miss Charlotte Smith of the National Aeronautics and Space Administration.

In round table discussions, the doctor-pilots exchanged views on such subjects as: engine maintenance, weather, instrument flying, and maximum aircraft performance. Their wives, many of whom serve as co-pilots, also had an opportunity to meet with other ladies to discuss their own flying experiences.

(Editor's Note: Membership applications and details on the Flying Physicians Association may be obtained from: Headquarters, Flying Physicians Association, 332 South Michigan Avenue, Chicago, Illinois 60604.)

P.M.S. "Student" Wins Heart Prize

The Pennsylvania Heart Association Undergraduate Research Prize has been awarded to a medical student attending Hahnemann on a scholarship from the Pennsylvania Medical Society.

Earl S. Herr, class of 1969, captured the award for research he executed under the preceptorship of Joseph Abbott, M.D., assistant director of the Cardiopulmonary Unit, San Francisco General Hospital, Calif.

Herr was a Lederle Laboratories Fellow for the research. His paper was entitled "Fidelity Requirements of Vascular Pressure Measurement Systems."

P. M. G. A. Awards Announced

The Pennsylvania Medical Golfing Association held its annual tournament, September 30, 1968, following the Annual Session of the PMS House of Delegates in Pittsburgh. Following are photographs and a listing of all winner categories, including meeting details.



Blue Shield Handicap Trophy—presented by James Klaproth (left) for Pennsylvania Blue Shield to winner H. R. Zeller, M.D., Pittsburgh.



Blue Shield Senior Championship Trophy—presented by James Klaproth (left) for Pennsylvania Blue Shield to winner Ken England, M.D., Roaring Spring.



McKee Cup Winner (Tournament Low Gross Score)—was Harold Fisher, York (left), presented by Bruce B. MacMillan, M.D., Pittsburgh.

Other awards included: First Flight: Low Gross—Harold Fisher, M.D., York Cty.; Low Net—Reginald B. Gemmill, M.D., York Cty.; 2nd Low Net—Rupert H. Friday, M.D., Allegheny Cty.; 3rd Low Net—Leo P. Sheedy, M.D., Allegheny Cty. Second Flight: Low Gross—Thomas J. Fritchey, M.D., Dauphin Cty.; Low

Net—Theodore C. Zeller, M.D., Allegheny Cty.; 2nd Low Net—John W. Roop, M.D., Warren Cty.; 3rd Low Net—William A. Gillinger, M.D., Allegheny Cty. Third Flight: Low Gross—Thomas E. Park, M.D., Fayette Cty.; Low Net—James A. Dull, M.D., Westmoreland Cty.; 2nd Low Net—Charles W. Weissner, M.D., Allegheny

Cty.; 3rd Low Net—Lewis W. Gerhart, M.D., Northumberland Cty.; 4th Low Net—Edward C. Lutton, M.D., Butler Cty. Fourth Flight: Low Gross—Harry R. Zeller, M.D., Allegheny Cty.; Low Net—Eugene A. Conti, M.D., Allegheny Cty.; 2nd Low Net—Edwin O. Daue, Jr., M.D., Dauphin Cty.; 3rd Low Net—Donald W. Gressly, M.D., Beaver Cty.

11 Prizes Awarded in Art Competition

The Pennsylvania Physicians Art Association presented exhibits and made awards in various categories as part of the State Society annual business session in Pittsburgh.

The categories and first prize winners were as follows: Primitive—Kelse M. Hoffman, M.D., of Franklin; Pastel—Mrs. J. Carl Baier, Williamsport; Woodcut—Mrs. Philip Jacobson, Williamsport; Color Photo—John M. Siegel, M.D., Allentown; Crafts—Mrs. John Munchak, Jr., Allentown; Street Scene—William J. Garner, M.D., Pittsburgh; Portrait—Henry B. Mussina, M.D., Williamsport; Silkscreen—Dr. Mussina; Collage—Mrs. Harold Thomas, Aliquippa;

Drawing—Mrs. Mark Konrad, Aliquippa.

Two second prizes were awarded—to Mrs. Frederick Lechner, Montoursville, for a portrait, and to Dr. Mussina for a pastel.

"Crisis in Health" Talk Slated by S. H. O.

Approximately 750 members are expected to attend the Fourth National Assembly of Student Health Organizations at Philadelphia's Warwick Hotel, November 7 to 10, 1968.

During the four days of assembly the members are scheduled to discuss and investigate the current crisis in health care, the organization's successes and failures so far in their attempt to deal with health problems, and the

programs they expect to adopt for the future.

Among recent activities of the Philadelphia segment of the S.H.O. has been a request from the Committee on Black Admissions to the city's medical schools to admit entering classes in September 1969 that are composed one-third of black students, to begin redressing the deficit of black physicians.

Guest speakers on the program include: George Wilson, M.D., chairman of the Medical Committee for Human Rights; Edmund Pellegrino, M.D., director of the Medical Center of SUNY at Stony Brook; John Holloman, M.D., past president of the National Medical Association; Walter Lear, deputy commissioner of Public Health in Philadelphia; Quentin Young, editor of "Health Rights New"; and Robb Burlage of the Health Policy Advisory Center.

When Should A Physician Assist The Surgeon?

When is it obligatory that an operating surgeon have a physician assistant present and scrubbed at the operating table? The Joint Commission of Accreditation of Hospitals stipulates that there must be a physician assistant present "in any procedure with unusual hazard to life."

The American College of Surgeons, as a member of the JCAH, supports this as a minimum requirement. The determination of what constitutes "unusual hazard" rests therefore with the conscience of the operating surgeon and is part of his responsibility to his patient, but the surgeon must be prepared to defend his decision before the medical staff and governing body of his hospital.

Ideally perhaps there should always be a competent surgeon backing up the operator during every surgical procedure in the event of an unanticipated accident to the latter. Such sudden incapacities must be rare indeed and their potentiality cannot be compared with the necessity for a co-pilot of a plane. There are frequent circumstances when it is clearly not feasible to have a second surgeon, or even a physician assistant, on the operating team. Moreover, there are simple procedures at which it would be superfluous to insist upon a physician assistant.

The problem is where to draw the line, and the delineation must be made by the conscience of the surgeon. It is fatuous to propose,

as certain medico-legal experts and even state licensing bodies have recently done, that there should be a physician assistant at every "major surgical operation." This begs the question. No group of surgeons has ever been able to agree upon a definition of "major" versus "minor" surgical procedures. The truth is that the degree of hazard of an operation lies not so much in the nature of the procedure itself as in the age, obesity, condition, etc. of the patient. These are the factors which the operating surgeon must evaluate in each case and which will determine what constitutes adequate assistance.

(American College of Surgeons Newsletter)

Dr. Farrar Defends House Action

Health Officials Deny Double Pay Charges

Recent newspaper reports alleging that a Commonwealth doctor had received more than \$55,000 from Pennsycare funds, mostly for delivering babies, and inferring that the Pennsylvania Medical Society is burying its head in the sand over such matters were declared "grossly misleading" by PMS President George E. Farrar, Jr., M.D., and "completely untrue" by Secretary of Public Welfare, Thomas W. Georges, Jr., M.D.

In the article which appeared in the Oct. 2, 1968, issue of the Philadelphia *Bulletin*, it was implied that physicians may be receiving double payment for baby deliveries and payment for services not personally performed.

Dr. Farrar questioned Dr. Georges about the published claims which quoted David J. Lieberman, M.D., Pennsycare administrator, in some of the statements as being upset because "staff physicians in major hospitals seldom deliver the babies of the poor—those deliveries are customarily performed by interns and residents." Dr. Georges said that Dr. Lieberman was incorrectly quoted.

The \$55,000 payment referred to was made to a group of obstetricians at a major metropolitan hospital, not to an individual physician, Dr. Georges said.

The facts are, according to Dr.

Georges, that payments for physicians' services in hospitals are processed by Blue Shield and pre-audited and subject to special audits by the Auditor General.

All services for which Medical Assistance payments are made are to be provided personally by the physician or under his personal supervision. Interns and residents at institutions providing Medical Assistance care are not reimbursed.

In group practice situations, Dr. Georges explained, payments may be made to the group as a matter of efficient administration, but each participating physician must follow the personal service mandate of the program.

Dr. Farrar noted that the same published report inferred that the Pennsylvania Medical Society avoided action on such issues in its annual meeting in Pittsburgh in September.

The *Bulletin* article stated: "A resolution, introduced by the Philadelphia County Medical Society, asked the state society to declare it unethical for a doctor to collect a fee 'unless the physician is personally present when the service is rendered.'"

"But the committee recommended that the resolution be studied by the state society's Judicial Council for legal review before adopting it as policy.

"Delegates agreed, by voice vote, meaning that the issue can't come before the policy-making House of Delegates again before next year, unless a special meeting of the House is called," concluded the *Bulletin* story.

"The report is grossly misleading," Dr. Farrar said, "because it has been declared unethical by the AMA Judicial Council for any physician to bill for services he has not personally performed or personally supervised."

In refuting the accusation of ostrich tactics, Dr. Farrar said "The State Society House of Delegates did refer a resolution on the subject to its own Judicial Council but only because ethics are determined by the Council and not by the House."

Lancaster M.D. Finds

Soviet Doctors Share Compassion, Concern

In Russia, "the average doctor is paid the same as the lady who is cleaning the street," yet the same "compassion and concern" for a patient is shared with doctors throughout the world, according to Harold K. Hogg, M.D., Lancaster surgeon who returned August 11 from a sixteen-day tour of Soviet-bloc hospitals with the Soviet-American Congress of Surgery.

The eighty-five-member tour, comprised of about 50 American doctors, most of them members of the American College of Surgeons, and their wives, visited hospitals in Moscow, Leningrad, Budapest and Vienna.

The doctors were friendly, and, according to Dr. Hogg, "there wasn't a thing we wanted to see that we couldn't." The Russians seemed extremely interested in surgery in the United States and questioned particularly the recent heart transplants, which the Russians have not yet accomplished.

Dr. Hogg said the reason Russians have not yet attempted heart transplants is that they do not yet have a heart-lung machine that can purify the blood for the length of time needed for such an operation.

Open heart surgery is not new to the Soviets, however, and Dr. Hogg is proud to have met the world-renowned Russian surgeon, N. M. Amosoff, who has performed over 2,000 open heart operations and is a co-designer of the Russian version of the artificial blood circulator, the AIK. The AIK's main limitation is that it can operate for only thirty to forty minutes and gives insufficient time for any advanced surgery.

Dr. Amosoff operates at the Moscow Institute of Cardiovascular Surgery, the hospital where all heart surgery in the Soviet Union is performed. It was the scene of one of the conferences of the Soviet-American Congress of Surgeons.

Dr. Hogg recalled that nearly every doctor in the hospital attended the first conference and they were standing in the aisles to hear American doctors speak on surgical techniques.

"The interpreter for the lecture, by the way," said Dr. Hogg, "was a Russian doctor educated at the Mayo Clinic. He spoke English very well



Harold K. Hogg, M.D.

and was very helpful in translating medical terminology."

The Americans invited the Russian doctors to evening social events following the conferences in the hope of learning more of the Soviet medical system. Although the Russians attended sparsely, those who came were eager to discuss medicine with the Americans. Medicine naturally led to world events and soon the Russians and Americans were comparing political systems. According to Dr. Hogg, the Russians were careful of what they said but were not holding back criticism for fear of reprimand from the Communists. In general Dr. Hogg found the Soviets pretty well satisfied with their system, and rightly so, considering that their standard of living has risen greatly, though it is still a far cry from that of Western Europe or the United States.

Knowing that a doctor's pay in Russia is relatively low, Dr. Hogg questioned a few Russian doctors on "why they bothered to study medicine?" Most of them answered that

they had always wanted to be doctors, and it was as simple as that. But some admitted that being a doctor put an individual on a higher social plane, even though a social stepladder is supposed to be non-existent under Communism.

The life is, in fact, much better. Doctors in Russia are paid to go to school, given better apartments in better districts, work only a six-hour day, and retire at age sixty with sixty per cent of their income for life and a forty per cent reduction in apartment rent.

And if a doctor practices at least twenty years, and becomes a professor, he may be able to afford a car on his salary of \$350 a month. They stress the fact that, under Communism, they will always have enough to eat and a place to live. Their selling point to Americans is security, Dr. Hogg said.

Dr. Hogg found the hospitals he visited a bit antiquated, but medically adequate. "They don't have a lot of the modern machinery we have," he said, "and I noticed a few brand names of American manufacturers on some of the equipment they do have.

At the Cardiovascular Hospital Dr. Hogg's party was shown one of four new operating rooms just built and not yet being used. "The Russians were eager to show off this part of their hospital to us," he said. It is as modern as anything we have in America and includes a windowed observation gallery and color TV monitors for closeups of the operative technique.

What advantages, if any, do the Soviets have over the Americans? Dr. Hogg cited a few. Most important, he thought, were the daily conferences the Russian doctors have. In the morning, he explained, all the doctors gather to discuss the day's surgery. At the end of their six-hour day, they gather again, over light refreshments, and review the day's results.

"We just can't do that here; we have office hours and our doctors are never all at the hospital at the same time," Dr. Hogg said.

There is not the doctor-nurse shortage which is a problem in the United States either. Over fifty-five per cent of all doctors in the Soviet Union are women, and there is an abundance of para-medical personnel. Autopsies are performed on all decedents. Permission from relatives is not required. According to Dr. Hogg, only about ten per cent of deaths in the United

States are autopsied because relatives will not grant permission. Dr. Hogg thinks this is detrimental to medical progress.

A Russian doctor is not subject to any malpractice laws. He can operate when he thinks it is necessary and no matter what the outcome, he suffers no consequences.

What are some of the major disadvantages of the Russian medical program? First, Dr. Hogg noted, from the time a Russian enters medical school he has little to say about his destiny.

The government selects the district he will serve, the hospital in which he will practice, and even the apartment in which he will live. A doctor's wife doesn't have an easy life just because her husband is a doctor. She must work, too. Any children the couple have are placed in the "kindergarten" at two weeks of age. Dr. Hogg cited an example. One of his tour guides was married to a doctor at the cardiovascular hospital.

In addition to the lack of medical equipment, the Russians also do not use disposable items such as linens and syringes, which are widely used in the United States. As far as drugs are concerned, the Russians admitted that just about everything they use is copied from the Americans and Western Europeans. Dr. Hogg returned home from the Soviet Union with new respect for the Russians, especially the doctors. He was pleased with their professional attitudes and their pride in their hospitals. He found the hospitals clean and the doctors very thorough in their work.

Dr. Hogg stated: "It's the same human body, whether it is black or white, rich or poor, Russian or American. Their patients are treated with the same compassion. (by Steve Guinter, *Lancaster News*)

27 MDs to Study Cancer Diagnosis Treatment in Phila.

The American Cancer Society reports that twenty-seven doctors and one dentist, sponsored by the ACS clinical fellowship program, will receive advanced, post-graduate training in cancer diagnosis and treatment this year, at ten approved Philadelphia medical schools and hospitals. The Society has allocated \$100,800 for those fellows being trained in Philadelphia institutions.

State News

D.P.W. Faces Reorganization

A reorganization in the Department of Public Welfare, reducing the number of program offices from five to four, and making other changes for more efficient administration of human services programs, was announced by Public Welfare Secretary Thomas W. Georges, Jr., M.D.

Deputy Secretary for Mental Health Joseph Adlestein, M.D., was redesignated as Deputy Secretary for Mental Health and Retardation. The Office of Public Information was designated as the Office of Public Relations.

An Office of Medical Services and Facilities, including the Medical Assistance program, was established under the direction of a physician, Alfred C. Kraft, M.D., former Acting Commissioner of General and Special Hospitals. The Medical Assistance program had previously been under the Office of Family Services in the

Department.

Dr. Georges explained that the activities of the former Office of General and Special Hospitals will continue in the new unit under the direction of Dr. Kraft, including the operation of 10 State-owned general hospitals.

In another administrative change, functions of the former Office for the Blind and Visually Handicapped will be revised to include activities for the physically handicapped and placed in the Bureau of the Visually and Physically Handicapped, Office of Family Services.

The office of family services will continue to direct the program of public assistance cash grants and social services and supervise or provide services in the field of aging and child welfare, including the operation of state-owned youth development centers and forestry camps.

Police Warned on Chemical Mace

In a letter to local police chiefs throughout Pennsylvania, Secretary of Health Thomas W. Georges, Jr., M.D., has urged law enforcement officers to consider "Chemical Mace" a "dangerous weapon, with a potential for permanent damage and disability until proven otherwise."

Dr. Georges said the U.S. Public Health Service has been reviewing available evidence regarding nature and effects of the non-lethal weapon known as "Chemical Mace" and related control agents containing chloroacetophenone.

Based on evidence developed from U.S. Public Health Service studies, Dr. Georges' recommendation to law enforcement officials is that "subjects controlled by the use of agents of this type be treated promptly and specifically" as well as "the police officer who may be exposed to the substance during its period of use.

"Ordinarily," Dr. Georges said, "flushing the areas of the body exposed to mace with water would constitute adequate treatment. If the exposure has been severe, gentle but copious flushing of the conjunctiva, fluorescein examination, and anti-inflammatory drops may be beneficial.

Salves, creams, or ointments should not be applied to skin until the chloroacetophenone has dissipated since they may retard its sublimation, promoting local irritation . . .

"In fact, absorption in the clothing of the kerosene-like solvent which is relatively non-volatile of itself can prolong the local action of chloroacetophenone and should be considered as a condition requiring treatment."

The effects of tear gas disseminated as a smoke or cloud in controlling crowds are well-known, he said, but "Chemical Mace" is different because of the localized nature of toxic agent application together with the presence of the relatively non-volatile solvent containing kerosene-like hydrocarbons, which would appear to prolong tissue exposure to the chloroacetophenone and may increase its irritant effects.

Dr. Georges added that while "Chemical Mace" is not covered by the Federal Hazardous Substances Act and does not fit within the definition of "drugs" under the purview of the Federal Food and Drug Administration, that agency plans to encourage further studies, particularly to determine possible chronic effects.

no

gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:

Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.

(Warning: May be habit forming)

To reduce hypermotility and frequency.

Homatropine Methylbromide... 0.15 mg.

A safe dose for mild spasmolysis to curb cramping and griping.

Pectin... 24. mg.

Demulcent, adsorbent. Helps form stools.

Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's dose): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID



INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

Ars Gratia Medicinae



Pennsylvania Hospital, the nation's first, has added an original touch to the practice of decorating construction fences on the hospital grounds where work is in progress on a new maternity-education-research building; a site that has actually turned into a unique art gallery.

The eye-catching originals were created by 15 young women—juniors and seniors majoring in advertising art at the Moore College of Art, Philadelphia. They were charged with the creation of a series of panels interpreting the story of the Hospital in a dramatic presentation.

Five Pa. Firms Accredited For Animal Care

Five Pennsylvania firms are among the ninety-nine listed by the American Association for Accreditation of Laboratory Animal Care as fully accredited laboratory animal facilities.

AAALAC was founded in 1965 by sixteen organizations interested in scientific research. Its function is to maintain high standards of care for laboratory animals and to provide a means of self-regulation by the scientific community. Prior to its founding, there was no national agency concerned with the accreditation of laboratories involved in animal research.

The Pennsylvania institutions include: McNeil Laboratories, Inc., Fort Washington; Merck Institute for Therapeutic Research, West Point; Merck Sharp & Dohme Veterinary Service and Veterinary Pathology, West Point; Smith Kline & French Laboratories Research & Development Division-Pharmaceuticals, Philadelphia, and Wyeth Laboratories Research & Development Division, Radnor.

A complete, nationwide list of accredited facilities may be obtained by writing to the Association at 4 E. Clinton St., P. O. Box 13, Joliet, Illinois 60434.

Prediction Reversed

Major Influenza Outbreak Seen

PENNSYLVANIA MEDICINE reported in the September 1968 issue the Public Health Service's prediction that little or no flu would occur in the eastern part of the nation this fall.

Most recent reports from that organization indicate a reversal of the calculation due to recent outbreaks in Hong Kong and Singapore of a strain of virus against which current vaccines will have little effect.

The "Hong Kong viruses" show a marked antigenic change from previous strains and although it is in the A2 family, existing vaccines offer only limited protection. Development and manufacture of a monovalent vaccine containing the "Hong Kong strain" is underway but it may not be available until December or later, and then in short supply.

With a major outbreak impending in the United States, the health service recommends that current bivalent and polyvalent vaccines be given only to persons in the highest risk group and that the same patients be revaccinated with the monovalent "Hong Kong" type as soon as it becomes available.

Pa. Blue Shield Expects 90% Return In Paid Benefits

Doctor care benefits to be paid by Pennsylvania Blue Shield in 1968 are expected to be nearly ninety percent of the annual subscription income which now exceeds \$112 million.

The prediction was made by Matthew K. Gale, president of the statewide health care financing plan, when he announced recently that Blue Shield is the first of the seventy-two plans in the country to pass the seven million mark in the number of persons served.

Another \$75 million is received by Blue Shield for the government programs it administers, bringing total income for the year to \$188 million. Total amount paid in benefits by Pennsylvania Blue Shield since its founding in 1939 now is more than \$943 million.

Blue Shield membership increased by over 96 thousand during the first six months of 1968. More than one million persons estimated to be eligible for benefits under the Pennsylvania Medical Assistance program were added to the total served by Blue Shield on June 1 when the company began processing claims for inpatient medical and surgical services performed in a hospital.

Focus on Military in Drive For Health Manpower

A group of hospitals in North Philadelphia has launched a program to recruit military personnel trained in the allied health fields. The aim is to help stem what is estimated to be the loss of 35,000 to 50,000 qualified servicemen to the civilian health economy each year.

Dr. Joseph Hirsh, executive director of the North Philadelphia Health Affiliates, Inc., said "the civilian health economy doesn't have an effective recruiting program. It goes around as if recruiting were a dirty word. Maybe we can learn something from industry in this regard."

Hirsh said the group is planning to send recruiters to military bases within a 50-mile radius of Philadelphia. Hirsh, an army reserve colonel on the Army Surgeon General's staff, said he has sent letters to the military Surgeons General requesting that the recruiters be allowed on the bases.

The affiliates are Temple University Health Sciences Center, Temple University Hospital, Temple University, Albert Einstein Medical Center, Episcopal Hospital, Germantown Dispensary and Hospital, Moss Rehabilitation Hospital, St. Christopher's Hospital for Children, Woman's Medical College and Woman's Medical College Hospital.

Nurse/Computer Duo Study Conducted

The application of computer-assisted information systems to hospital nursing stations will be studied and evaluated over a ten-month period by Lockheed Missiles and Space Company, Sunnyvale, California, under a contract with the National Center for Health Services Research and Development of the Health Services and Mental Health Administration. Recommendations on how to automate most effectively the flow of information through a typical nursing station should lead to a reduction in the paper work which now consumes 40 percent of a hospital nurse's time.

Ambulance Drivers Complete Course

More than 7,000 ambulance personnel have voluntarily completed the Ambulance Attendant Training Course offered by the Pennsylvania Department of Health.

With a growing shortage of physicians and an increasing volume of accidents and medical emergencies, Pennsylvania's counties like those across the nation depend more and more on ambulance transportation and fast paramedical treatment.

Pennsylvania's volunteer training course, already recognized as one of the most advanced in the nation, is conducted by the Health Department's Division of Environmental Safety in a unique cooperative effort involving local physicians, hospitals and attendants—all of whom have volunteered their time, effort and facilities to help reduce death and injuries in their communities.

There are about 1,860 ambulances and similar emergency vehicles in the state, maintained by 877 ambulance organizations of all kinds, including hospitals, voluntary and commercial associations, fire companies and other

groups.

Of the personnel of these vehicles, 7,608 drivers and other personnel have completed the State's courses, with almost every county in the State supporting the training programs.

The courses, usually arranged by county medical societies, are taught by volunteer physicians, Red Cross workers, State Police and other qualified instructors without cost to the program. More than 7,500 hours of instruction have been provided free by local physicians. The courses, given in the evenings at hospitals, schools and fire company halls, consist of 22 hours of varied instruction. In several experimental projects, ambulance attendants are being given an opportunity to work in hospital emergency rooms as a new training experience.

Local communities desiring further information on the popular training course or manual may contact Henry L. Albert, director of the Division of Environmental Safety, Department of Health, P.O. Box 90, Harrisburg, Pennsylvania, 17120.

AMA Distaffers to Attack Violence

An all-out campaign to put an end to the violence sweeping our nation has been launched recently by the Woman's Auxiliary to the American Medical Association.

In a statement outlining the program, Mrs. C. C. Long, Auxiliary president, said, "Violence kills and maims as surely as disease. It can irreparably blight our lives and darken the future of every young person unless we act to stop it."

Mrs. Long urged auxiliaries to give this violence campaign top priority among current activities. She stated that while much is being written about the situation, more action should be directed to the decision-making people responsible for the programming and content of TV and motion picture productions.

To implement the project, county and state auxiliaries should:

- Appoint action committees to meet with local managers of all TV stations, owners or managers of movie

chains and individual theatres, and heads of advertising.

- Form joint action groups with PTAs, Leagues of Women Voters, church women's groups, and teachers, urging participation and support of community forums on violence.

- Set up viewing and screening schedule to monitor all shows, keeping records of the degree, frequency, time, etc. of violence on each station and in each theatre without giving an appearance of censorship or of boycott.

- Feed this information regularly to local TV critics, editorial writers and movie reviewers as background for their commentaries.

- Launch letter-writing campaigns to presidents of national advertisers, TV networks, advertising agencies and movie producers, emphasizing the auxiliary's concern for sound health education.

- Write presidential candidates encouraging programs to end violence in our nation.

Play Dirt is Pay Dirt



... Governor Raymond P. Shafer heaves first shovelful of dirt at ground-breaking for new \$40 million Children's Hospital and Child Guidance Center, Philadelphia. Participating at the ceremony are William L. Van Alen (left), chairman of the board of managers of the hospital and Richardson Dilworth, chairman of the hospital's building fund committee. Children are those of hospital staff members.

MDs Urged to Participate

Accident Prevention Course Slated at U.C.L.A.

Based on the premise that accident investigation could discover clues leading to accident prevention, physicians throughout the country are being asked to participate in a proposed investigation. Selected physicians and police officers from various areas of the country will be given an intensive three-day course at UCLA and other universities. Sponsored by the American Medical Association's Committee on Medical Aspects of Automotive Safety, the project will consist of having these teams gather scientific data from automobile accidents.

H. A. Fenner, Jr., M.D., Hobbs, N. M., Committee chairman, said that every traffic accident presents a "tremendous opportunity in its tragic toll of human and mechanical wreckage to discover clues to prevention." Supporting this thought, he pointed out that many of the safety devices on present-day automobiles and highways resulted from traffic accident research.

"Most accident reports at the present are related to law enforcement rather than to research-oriented data collection," according to Dr. Fenner.

Temple Disputes Crib Death Study

Researchers at Temple University Health Sciences Center today disputed a published study indicating that deficient parathyroid glands could be the primary cause of the mysterious "crib death" which kills 20,000 infants a year.

Research conducted under the supervision of Marie Valdes-Dapena, M.D., associate professor of pathology at St. Christopher's Hospital for Children, showed that there was no significant difference in the number or function of the parathyroid glands among cases of crib death and control cases.

It had been suggested previously by Preben Geertinger, M.D., of Sweden that a congenital deficiency of parathyroid tissue was the primary cause of the crib deaths, which have baffled medical investigators for nearly ten years.

Dr. Valdes-Dapena, a pioneer in the quest to explain the "sudden death syndrome," and Donald Weinstein, a third year student at Temple University School of Medicine, conducted their study of 130 cases this summer under a grant from the National Institutes of Health.

"However, if we had a corps of knowledgeable, trained and qualified physicians and police officers to provide accurate, scientific reports on a large number of accidents, automotive engineers would have the right kind of data to translate into safer motor vehicles and highways," he emphasized.

Any interested physician should send his name, address, age, medical college, and field of practice to the A.M.A. Committee on Medical Aspects of Automobile Safety, 535 N. Dearborn Street, Chicago, Illinois 60610.

in the complex picture
of moderate to severe anxiety...



There is a **new** reason
for prescribing **Mellaril**
(Thioridazine HCl)

**Effectiveness in
mixed anxiety-depression**

Long recognized for its usefulness in the
treatment of moderate to severe anxiety,
Mellaril is now also known to be effective
against mixed anxiety-depression.

Even the symptoms of anxiety states are
difficult to sort out—even with the most careful
probing. The patient may manifest symptoms of
irritation, restlessness, insomnia, somatic
complaints. But what of the depression that may
be mixed in the total picture? It is reassuring
to know that Mellaril may be prescribed—with
promising possibilities of success—when there is
anxiety alone or a mixture of anxiety
and depression.

Before prescribing or administering, see Sandoz
literature for full product information, including
adverse reactions reported with phenothiazines. The
following is a brief precautionary statement.

Contraindications: Severe central nervous system
depression, comatose states from any cause,
hypertensive or hypotensive heart disease of
extreme degree.

Warnings: Administer cautiously to patients who
have previously exhibited a hypersensitivity reaction
(e.g., blood dyscrasias, jaundice) to phenothiazines.
Phenothiazines are capable of potentiating central
nervous system depressants (e.g., anesthetics,
opiates, alcohol, etc.) as well as atropine and
phosphorus insecticides. During pregnancy,
administer only when necessary.

Precautions: There have been infrequent reports of
leukopenia and/or agranulocytosis and convulsive
seizures. In epileptic patients, anticonvulsant
medication should also be maintained. Pigmentary
retinopathy may be avoided by remaining within the
recommended limits of dosage. Administer
cautiously to patients participating in activities
requiring complete mental alertness (e.g., driving).
Orthostatic hypotension is more common in females
than in males. Do not use epinephrine in treating
drug-induced hypotension. Daily doses in excess of
300 mg. should be used only in severe
neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—
Drowsiness, especially with large doses, early in
treatment; infrequently, pseudoparkinsonism and
other extrapyramidal symptoms; nocturnal
confusion, hyperactivity, lethargy, psychotic
reactions, restlessness, and headache. *Autonomic
Nervous System*—Dryness of mouth, blurred vision,
constipation, nausea, vomiting, diarrhea, nasal
stiffness, and pallor. *Endocrine System*—
Galactorrhea, breast engorgement, amenorrhea,
inhibition of ejaculation, and peripheral edema.
Skin—Dermatitis and skin eruptions of the urticarial
type, photosensitivity. *Cardiovascular System*—
Changes in the terminal portion of the
electrocardiogram have been observed in some
patients receiving the phenothiazine tranquilizers,
including Mellaril (thioridazine hydrochloride).
While there is no evidence at present that these
changes are in any way precursors of any significant
disturbance of cardiac rhythm, several sudden and
unexpected deaths apparently due to cardiac arrest
have occurred in patients previously showing
electrocardiographic changes. The use of periodic
electrocardiograms has been proposed but would
appear to be of questionable value as a predictive
device. *Other*—A single case described as
parotid swelling.

Mellaril[®]
(Thioridazine HCl)
25 mg. t.i.d.

**for moderate to severe anxiety
and mixed anxiety-depression**



SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J.

68-170



Louie!
You're
back.

Louie lost weeks with acute shoulder bursitis. That's a lot of pain, stiffness and tenderness...and also a lot of fish. It might have been different with **Butazolidin®** alk

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forget

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a

latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-B

**For complete details,
please see full prescribing information.**

Geigy Pharmaceuticals 
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

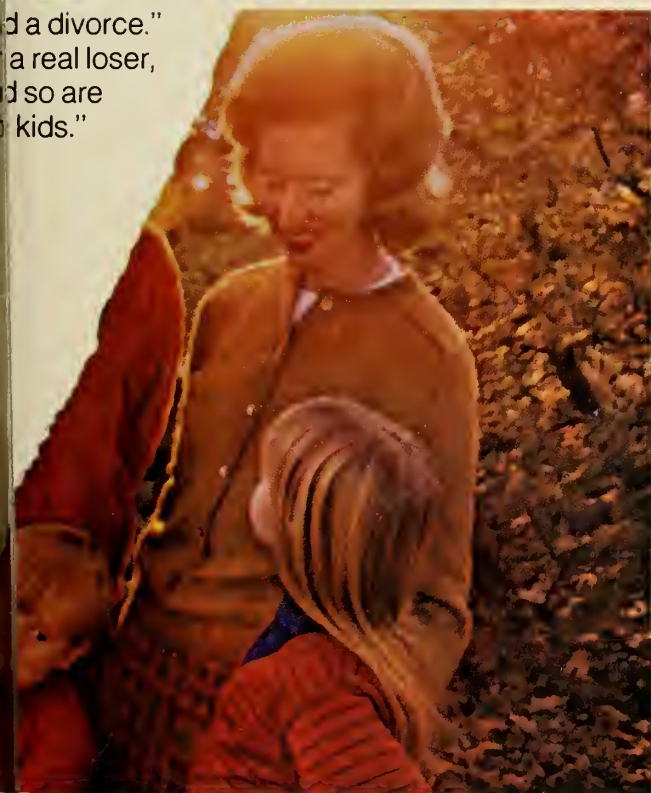
The “Forty,
Divorced Depressive:
Forgotten

“Had a large wedding.”
“Had a fine home and family.”



Forlorn"

d a divorce."
a real loser,
d so are
kids."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy—the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil[®] imipramine
Geigy hydrochloride

in depression



Tofrānil®, imipramine hydrochloride

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.

Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.

Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.

Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure. In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.

The drug is not recommended at the present time in patients under 12 years of age.

Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and

Tofrānil® Geigy

imipramine
hydrochloride

vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).

Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.

A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.

Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration. (B)R-46-850-C

For complete details, please refer to the full Prescribing Information.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Dilantin® (diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anti-convulsant drugs.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. **ADVERSE**

REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred. DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.

Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS

01867



Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

newsfronts

Woman's Auxiliary to the Pennsylvania Medical Society

Forty-Fourth Annual Convention

September 26-29, 1968
Pittsburgh

During the 44th Annual Convention of the Woman's Auxiliary to the Pennsylvania Medical Society, Mrs. Axel K. Olsen of Villanova was installed as president and Mrs. John A. Schneider of Pittsburgh was elected president-elect.

The following awards were presented: American Medical Association Education and Research Foundation—Wyoming County; Education Fund—Mifflin-Juniata County and Medical Benevolence Fund—Greene County.

The House of Delegates voted to increase the State Auxiliary dues to \$4.00, effective 1970.

Amendments to the By-laws were adopted as printed in the convention program.

Following are names of delegates elected by the House of Delegates and the Board of Directors to attend the 1969 Annual Convention of the Woman's Auxiliary to the American Medical Association: Mrs. Axel K. Olsen, chairman, Mrs. Jacob Ripp, Mrs. Manuel A. Bergnes, Mrs. A. Wesley Hildreth, Mrs. Frank J. Corbett, Mrs. Leroy A. Gehris, Mrs. Alfred W. Crozier, Mrs. John W. Eves, Mrs. Stephan D. Locky, Mrs. C. Henry Bloom, Mrs. Richard C. Taylor, Mrs. Donald L. McMillan, Mrs. Raymond C. Grandon, Mrs. Lucian J. Fronduti, Mrs. Ralph S. Blasiole, Mrs. John A. Schneider, Mrs. J. Antrim Crellin, Mrs. James W. Minter and Mrs. William A. Sode-man.



New Auxiliary officers are, l. to r., Mrs. John H. Eves, Eastern Regional Vice-president; Mrs. Frederick R. Gilmore, First Vice-president; Mrs. John A. Schneider, President-elect; Mrs. Axel K. Olsen, President; and Mrs. Stephan D. Locky, Central Regional Vice-president. Standing are l. to r., Mrs. Donald L. McMillan, Western Regional Vice-president; Mrs. Frank J. Corbett, Treasurer; Mrs. Alfred T. Johnson, Recording Secretary; Mrs. C. Henry Bloom, Financial Secretary; Mrs. Leroy A. Gehris, Speak-

er, House of Delegates; Mrs. Frank R. Kinsey, Councilor, Sixth District; Mrs. E. Howard Bedrossian, Councilor, Second District; Mrs. Donald R. Pohl, Councilor, Eleventh District; Mrs. Robert N. Moyers, Councilor, Eighth District; and Mrs. William R. A. Boben, Councilor-elect, Twelfth District. Not pictured are Mrs. Thomas E. Patrick, Councilor-elect, Fourth District and Mrs. William S. Keck, Councilor-elect, Tenth District.



Auxiliary leadership changes as Mrs. Axel K. Olsen receives the gavel from Mrs. Jacob Ripp.



Gavel Club members met, and elected Mrs. John M. Wagner president. Seated, l. to r., are: Mrs. Jay G. Linn, Mrs. John M. Wagner, Mrs. Laurie D. Sargent, Mrs. Walter F. Donaldson, Mrs. Willis A. Redding and Mrs. Allison J. Berlin. Standing, same order, are Mrs. Alfred W. Crozier, Mrs. A. Wesley Hildreth, Mrs. Lucien J. Fronduti, Mrs. Manuel A. Bergnes, Mrs. Jacob Ripp, Mrs. Daniel H. Bee, Mrs. Alfred F. Doyle and Mrs. Edward P. Dennis. Not Pictured are Mrs. W. Wayne Babcock, Mrs. Edgar S. Buyers, Mrs. Frank P. Dwyer, Mrs. Charles L. Shafer, Mrs. Charles B. Forcey, Mrs. John H. Doane, Mrs. Maxwell Lick, Mrs. Walter Orthner, Mrs. Leon C. Darrah, Mrs. Charles J. Swahn, Mrs. Rufus M. Bierly, Mrs. Paul C. Craig, Mrs. Drury Hinton, Mrs. Howard H. Hamman, Mrs. Frederic H. Steele, Mrs. Herbert C. McClelland, Mrs. Harry W. Buzzard, Mrs. Walter H. Caulfield, Mrs. Malcolm W. Miller and Mrs. Robert F. Beckley.

painful night leg cramps...

respond to specific therapy with QUINAMM™
(Quinine sulfate, 260 mg., Aminophylline, 195 mg.)

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



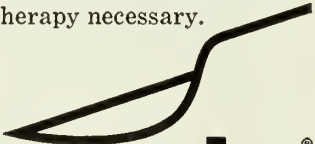
THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem,
or simply nervousness and anxiety, Parepectolin
will bring the diarrhea under control until etiolo-
gy can be determined. In some cases, Parepec-
tolin may be all the therapy necessary.



Parepectolin®

Each fluid ounce of creamy white suspension contains:

*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid
ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three
times daily.

Usual Children's Dose: One or two teaspoonfuls three
times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

newsfronts



Chairmen of the 44th Annual Convention are shown
above. They are Mrs. Daniel W. Elliott, co-chairman, and
Mrs. James E. McMillan, chairman.



The President introduces the 1968-69 committee chair-
men. Seated, l. to r., are: Mrs. John J. Canfield, Inter-
national Health Activities Chairman; Mrs. Robert L.
Harding, Legislative Chairman; Mrs. Axel K. Olsen, Presi-
dent; Mrs. Richard C. Reinsel, Educational Fund Chair-
man; and Mrs. Edwin S. Kremer, Jr., Safety-Disaster-pre-
paredness Chairman. Standing, same order, are: Mrs.
Fred G. Holt, American Medical Association Education
and Research Foundation Chairman; Mrs. Delmar R.
Palmer, Necrology Chairman; Mrs. John S. Bray, Pub-
licity Chairman; Mrs. A. Wesley Hildreth, By-laws Chair-
man; Mrs. C. Henry Bloom, Finance Chairman; Mrs. James
M. O'Leary, Health Careers Chairman; and Mrs. David
J. Keck, Mental Health Chairman. Not pictured are Mrs.
Richard T. Smith, Medical Benevolence Fund Chairman
and Convention Chairman; Mrs. Frederick R. Gilmore,
Membership Chairman; Mrs. Jacob Ripp, Nominating
Chairman; Mrs. John A. Schneider, Program Development
Chairman; Mrs. Robert E. Barto, Jr., Publications Chair-
man; Mrs. William R. Adams, Community Health Chair-
man; Mrs. J. Thomas Millington, Conference Chairman;
and Mrs. Achilles A. Berettini, Home-centered Health
Care Chairman.

Quality and Economy for Drugs

GEORGE E. FARRAR, JR., M.D.,

Chairman, American Society of Internal
Medicine Pharmaceutical
Industry Committee, (1967-1968)

The debate between the advocates of generic prescribing and those who support the use of trademarked drugs is symptomatic of the growing concern about the cost of medical care. The following information may help to explain the implications of suggested legislation.

What creates a difference in the price of generic and trademarked drugs? Henry F. DeBoest, vice president of Eli Lilly and Company, in testifying before the Monopoly Subcommittee of the Senate Select Committee on Small Business, gave four reasons for difference in price:

1. *Manufacturing excellence* (quality control).
2. *A full product line* available in nearly every county of the fifty states (the most useless drug is the one that isn't there).
3. *Information Services* for the physician by well-trained "detail men," by company scientists answering questions by mail, telephone, and in person, and by packaging for convenience of patient and physician (*i.e.*, unit doses).
4. *Product improvement and new product development* resulting from basic research, to solve practical problems, to improve production methods and from the development and testing of products for better therapeutic action.

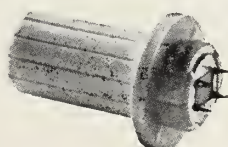
Senator Long estimates that a federal formulary with fixed price range would save \$100 million per year for drugs under Titles XVIII and XIX. Certainly, cheaper drugs can be purchased. Yet, all of the suggestions for generic prescribing emphasize economy and *assume* quality. It could cost the Food and Drug Administration millions of dollars per year to police the market in order to assume quality.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?

or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST

(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).



Ask your representative for details or write Medical Advisory Dept.,
Lederle Laboratories, Pearl River, New York 10965. 406-8

Q. How much does
the **anticoptive***
hematinic cost?

A. No more than
costive hematinics
cost!

The anticoptive hematinic is **PERITINIC®** Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate).....	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron).....	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C.....	200 mg
Niacinamide.....	30 mg
Folic Acid.....	0.05 mg
Pantothenic Acid.....	15 mg

Bottles of 60



anticoptive, *adj.* (*anti* opposed to
+ *costive* causing constipation.)
Against constipation. Now isn't
that a good idea in an iron-containing
hematinic?

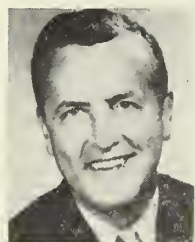


LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965



close-up/MD's

Peter V. Moulder, M.D., has been named director of the department of surgery at Pennsylvania Hospital, Philadelphia. The announcement was made by T. Truxtun Hare, Jr., president. Dr. Moulder assumed the post on Oct. 1. Dr. Moulder comes to Pennsylvania Hospital from the University of Chicago, where he was a Professor in the Department of Surgery and an Attending Surgeon in Cardiovascular and Thoracic Surgery.



DR. MOULDER

William K. Riker, M.D., professor of pharmacology at The Woman's Medical College of Pennsylvania and a 1968 recipient of the Christian R. and Mary F. Lindback award for distinguished teaching, has been appointed chairman of WMC's department of pharmacology. He was also recently made Specific Field Editor for *Neuropharmacology*, *The Journal of Pharmacology and Experimental Therapeutics*, and became a new member of the National Institute of General Medical Sciences' Pharmacology and Toxicology Training Committee.

John J. McGraw, M.D. has been appointed director of the department of pathology at Bryn Mawr Hospital. Dr. McGraw is board certified in anatomical and clinical pathology and was formerly the director of the department of pathology at Lower Bucks and Doylestown hospitals.

Stanley C. Clader, M.D. has been appointed director of the department of obstetrics and gynecology at Bryn Mawr Hospital, succeeding **John Y. Howson, M.D.**

A two-year federal grant to Philadelphia's Albert Einstein Medical Center for the study of antibiotic compounds has been announced by **Pascal F. Lucchesi, M.D.**, executive vice president and medical director. **Robert J. Suhadolnik, M.D.** is the principal investigator for the study.

Glen Brubaker, M.D., Lancaster, is serving a three-year tour at the leprosarium in Shiriti, Tanzania, East Africa.

William B. West, M.D., Huntingdon, has been confirmed by the State Senate as a member of the State Board of Medical Education and Licensure.

Earl Henderson, M.D., was given a plaque from the PMS to acknowledge his fifty years as a physician at the annual banquet of the Lawrence County Medical Society. **Wilbur E. Flannery, M.D.**, received a "Voice of Medicine" certificate for his service to the PMS Speaker's Bureau.

Lewis T. Patterson, M.D., Camp Hill, has been appointed director of surgery at the Harrisburg Polyclinic Hospital.

William L. Winters, Jr., M.D., Wynnewood, has been named president of the Heart Association of Southeastern Pennsylvania.

Dr. Victor J. Baluta, M.D., of Shamokin was honored at the seventy-eighth annual dinner of the St. Francis Seraficki Society when he was awarded the Polish-American Friar's Award for outstanding public service by a person of Polish-American heritage.

Charles Fox, M.D., Vandergrift, was a delegate to the Democratic National Convention in Chicago. He was elected from the northern district of Westmoreland County in the primary election.

Francis H. Adler, M.D., emeritus professor of ophthalmology at University of Pennsylvania Hospital, has received the first annual Dora Bernstein Memorial Award from the Fight for Sight League of Greater Philadelphia.

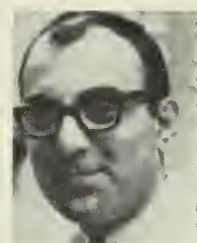
John D. Paul, Jr., M.D., Lancaster, will spend part of November and December, 1968, in India on a short-term voluntary medical missionary assignment for the United Presbyterian Church. Mrs. Paul will travel with her husband and serve as medical technologist. This will be the third

such trip made by Dr. and Mrs. Paul to a foreign country. They also served a volunteer period in mission work in New Mexico. Their work in India will involve cancer detection and population control.

James J. D'Luzansky, M.D., Altoona, has been made a fellow of the American College of Surgeons in ceremonies held at the Conrad Hilton Hotel, Chicago, recently.

Herbert F. Gretz, M.D., of Athens has become an associate in the section of obstetrics and gynecology of the Guthrie Clinic.

Evangelos T. Angelakos, M.D., Ph.D., has been named professor and chairman, Department of Physiology and Biophysics, Hahnemann Medical College and Hospital of Philadelphia. Dr. Angelakos has been continuously associated with the Boston University School of Medicine since 1952 and was most recently professor of physiology there.



DR. ANGELAKOS

Richard M. Gladding, M.D., of Leighton has closed his office there to accept a post-doctoral fellowship at Drexel University. A National Institute of Health grant will permit Dr. Gladding to work for a doctorate in bio-medical engineering.

Robert F. Babskie, M.D., Nanticoke, has been named acting head of Retreat State Hospital, Luzerne County. He succeeds **Robert Gatski, M.D.**, Danville, who has served as acting head of the 1,100-bed mental facility since last May, while also serving as superintendent of Danville State Hospital, a post he has held for fourteen years.

W. D. Schrack, M.D., of Etters, director of the division of communicable diseases of the State Health Department, recently received the annual

award of merit of the Pennsylvania Public Health Association. Dr. Schrack was cited for his outstanding contribution to the field of public health in the state.

Alexander R. Minno, M.D., Pittsburgh, has been selected as a councilor of the Lahey Clinic Foundation Alumni Association. The first reunion meeting of the association is scheduled for this fall.

The Berks County Medical Society recently accepted five physicians into membership. They are: **Nicholas T. Agouridis, M.D.**, **John W. Beem, M.D.**, **John R. Loughhead, M.D.**, **Manny H. Moser, M.D.**, and **Samuel C. Slimmer, M.D.**

William H. Jeffreys, M.D., director of neurology at the Geisinger Medical Center, has been named adjunct professor of bioelectronics at the Pennsylvania State University. He will continue in his post at Geisinger.

James McDonald Miller, M.D., Montrose, has been appointed to the consulting staff of Tyler Memorial Hospital. He will serve as internal medicine consultant.

Herbert R. Moskow, M.D., has been appointed to the staff of Pennsylvania Hospital's Community Mental Health Center as clinical director of the outpatient department. The announcement was made by **James R. Harris, M.D.**, coordinator of the center. Dr. Moskow has also been named an instructor in the department of psychiatry at the University of Pennsylvania School of Medicine.

John McMillen Mennell, M.D., chief of physical medicine and rehabilitation at Philadelphia General Hospital, presided at the second annual meeting of the North American Academy of Manipulative Medicine in Montreal, Canada, August 26 to 30. Dr. Mennell presented a paper, *Rationale of Joint Manipulation*, as part of the Fifth International Congress of Physical Medicine and Rehabilitation.

Albrecht W. Schmitt, M.D., Clinical Assistant Professor in the Department of Gynecology and Obstetrics at Woman's Medical College of Pennsylvania participated in an International Symposium on Early Lesions of the Cervix Uteri, held in Hamburg, Germany. Dr. Schmitt reported about

studies on menstrual flow which were performed with **C. Sauco, M.D.**, and **E. R. Carrington, M.D.**

Edward H. Bishop, M.D., has been elected president of the Obstetrical Society of Philadelphia. Serving with him are: **Elsie R. Carrington, M.D.**, president-elect; **Lennard L. Weber, M.D.**, vice-president, **John J. Mikuta, M.D.**, secretary and **Joseph J. Price, M.D.**, treasurer.

William A. Sodeman, M.D., scientific director of the Life Insurance Medical Research Fund, and dean emeritus and professor of medicine emeritus of the Jefferson Medical College of Philadelphia, has been named a member of the Board of Directors of the Inter-American Society of Cardiology. Dr. Sodeman was named at the Eighth Congress of the Society, held at Lima, Peru, last spring.

Five members of the Faculty of Temple University School of Medicine have been honored for completing twenty-five years of continuous teaching service. Inducted into the University twenty-five year club and presented pins were: **John B. Bartram, M.D.**, professor of pediatrics, **Norman Kendall, M.D.**, clinical professor of pediatrics, **Bernard J. Ronis, M.D.**, chairman of the department of otorhinology, **Charles R. Shuman, M.D.**, professor of medicine, and **Henry T. Wycis, M.D.**, clinical professor of neurosurgery.

George W. Schemm, M.D., a neurosurgeon, whose special interests are in diseases that affect blood vessels in the brains, has been appointed associate professor and chief of the neurosurgery division at Woman's Medical College of Pennsylvania. The appointment was



DR. SCHEMM

announced by **Donald R. Cooper, M.D.**, professor and chairman of WMC's Department of Surgery, under whom Dr. Schemm will work. Dr. Schemm comes to the college from the University of Oregon Medical School where he was Assistant Professor of Neurosurgery, and did extensive cerebrovascular research with emphasis on cerebral aneurysms.

Eugene H. Mohr, M.D., who has practiced medicine in Alburdis for more than forty years, was honored at a testimonial recently by civic leaders, city officials, and over 500 area residents, who presented a "This is Your Life" program of Dr. Mohr's career.

Robert G. Stevens, M.D., Williamsport, was a speaker at the annual conference of the Governor's Committee on Employment of the Handicapped. His topic was **Breaking Down Barriers to Build New Opportunities**.

Leonard S. Girsh, M.D., has been installed as president and chairman of the Board of Regents of the Pennsylvania Allergy Association. Dr. Girsh is assistant professor of internal medicine-allergy at Temple University Medical Center and director of the allergy department at St. Christopher's Hospital for Children, Philadelphia.

Elizabeth S. Waugh, M.D., of Philadelphia, spoke on "Methods of Birth Control" before the Congress of the Medical Women's International Association held in Vienna last summer.

S. Leon Israel, M.D., editor of *Obstetrics and Gynecology*, has been elected president of the Professional Staff, Department of Sick and Injured of Pennsylvania Hospital, Philadelphia. He is director of the hospital's division of obstetrics and gynecology, and professor of obstetrics and gynecology, University of Pennsylvania School of Medicine.

Bernard J. Ronis, M.D., has been elected president of the Philadelphia Laryngological Society and vice-president of the Pennsylvania Academy of Otolaryngology and Ophthalmology. He is chairman of the department of otorhinology at Temple University School of Medicine.

Lewis K. Hoberman, M.D., and **I. W. Ginsburg, M.D.**, of Temple University School of Medicine have received the Christian R. and Mary F. Lindback Foundation award for distinguished teaching.

L. W. Krumperman, M.D., has been re-elected assistant secretary of the Section of Anesthesiology, American Medical Association. He is a member of the faculty of Temple University School of Medicine.

Stanley Schor, M.D., has been appointed to the editorial board of *Diseases of the Chest*, the official pub-

(Continued next page)

close-up/MD's

lication of the American College of Physicians. Dr. Schor is on the faculty of Temple University School of Medicine.

Pascal F. Lucchesi, M.D., executive vice president and medical director of Albert Einstein Medical Center, has been awarded the first public relations award of the American Hospital Association. It was for a speech Dr. Lucchesi delivered on Sept. 29, 1967, before a hospital



DR. LUCCHESI

public relations symposium in Pittsburgh. The speech was entitled: *The Hospital Public Relations Executive and Hospital Administration*.

N. David Charkes, M.D., of Temple University School of Medicine recently presented an exhibit **Stereoscintophotography** at the fifteenth annual meeting of the Society of Nuclear Medicine.

D. Berkowitz, M.D., of Temple University School of Medicine, has been named editor of the National Institute of Health publication, *Gastroenterology Abstracts and Citations*. **S. P. Bralow, M.D.**, and **W. Chey, M.D.**, were named associate editors.

John Royal Moore, M.D., of the Temple University School of Medicine recently addressed a combined meeting of the British and German Orthopaedic Societies of cartilaginous cup arthroplasty. The meeting was held in Weisbaden, Germany.

Michael Scott, M.D., of the Temple University School of Medicine recently spoke at Morristown Memorial Hospital, Morristown, N. J., on the diagnosis and treatment of brain tumors.

Melvin S. Heller, M.D., addressed the Fourth Annual Sentencing Institute of the Crime Commission of the Philadelphia and Pennsylvania Conference of State Trial Judges. Dr. Heller, a member of the Temple University School of Medicine faculty, spoke on violence and the courts. The session was held at Bedford Springs.

Torsten Almen, M.D., and **Mary P. Wiedeman, M.D.**, attended the Inter-

national Congress of Microcirculation in Gothenburg, Sweden, recently. They are members of the faculty of Temple University School of Medicine.

The promotion of ten faculty members to full professors, the appointment of two new professors, one a dual appointment, and an additional appointment for a professor already in the faculty were announced at the opening exercises of the Jefferson Medical College by **William F. Kellow, M.D.**, dean and vice-president. The promotions are **Harold F. Chase, M.D.** (anesthesiology), **Kay Adrian O. Ellem, M.D.** (pathology), **Richard A. Field, M.D.** (medicine), **Daniel Lieberman, M.D.**, (psychiatry, community mental health), **Roland W. Manthei, M.D.** (pharmacology), **Albert E. O'Hara, M.D.** (radiology), **John J. O'Keefe, M.D.** (clinical otolaryngology), **Irving J. Olshin, M.D.** (pediatrics), **Edwin W. Shearburn, M.D.** (surgery), and **Martha E. Southard, M.D.** (radiology). **Richard G. Berry, M.D.**, professor of neurology, received an additional appointment as professor of pathology. **Frank D. Gray, M.D.**, was named a professor of medicine, and **Leonard J. Graziani, M.D.**, received a dual appointment as professor of neurology and of pediatrics.

Howard Balin, M.D., has been appointed adjunct professor of biological sciences at Drexel Institute of Technology. This appointment helps formalize an interdisciplinary liaison of his Gynecic Research Unit with the Biomedical Engineering and Endocrine Chemical Laboratories of Drexel Institute.

Joseph S. Torg, M.D., a member of the department of orthopaedics at Episcopal Hospital and instructor in orthopaedics at Temple University School of Medicine, is participating in the CARE-MEDICO program in Santiago, Dominican Republic. On September 1, Dr. Torg flew to Santiago where he has been assigned to the MEDICO unit at the Jose Maria Cabral Hospital to instruct Dominican physicians in advanced orthopaedic methods and procedures.

John W. Combs, M.D., has been appointed assistant professor of pathology at The Pennsylvania State University College of Medicine at the Milton S. Hershey Medical Center. Dr.

Combs had been a senior fellow in pathology at the University of Washington School of Medicine.

Eugene J. Van Scott, M.D., dermatologist and winner of several awards for research, has been appointed associate medical director of the Skin and Cancer Hospital at Temple University Health Sciences Center in Philadelphia. Dr. Van Scott will also hold the rank of professor of dermatology at the Temple School of Medicine.

Vince L. Hutchins, M.D., has been appointed project director of the Comprehensive Health Care Program for Children and Youth of Women's Medical College of Pennsylvania. **Doris Howell, M.D.**, chairman of the department of pediatrics, announced the appointment of Dr. Hutchins, who comes to Philadelphia from San Francisco, where he was engaged in private pediatrics practice, and served as assistant professor of pediatrics at the University of California's San Francisco Medical Hospital.

George E. Ruff, M.D., associate professor of psychiatry, School of Medicine, University of Pennsylvania, spoke at the 75th annual commencement exercises of the School of Nursing of the Hahnemann Medical College and Hospital Philadelphia. **Charles S. Paxson, Jr.**, vice president and administrator, presided at the ceremonies in which fifty-one graduates received the Hahnemann diploma and pin.

Harry C. Stamey, M.D. has been appointed a staff member in the department of psychiatry of The Geisinger Medical Center. For



DR. STAMEY

The past two years, Dr. Stamey has been director of out-patient and adolescent services at Danville State Hospital. A native of Lewis town, Pa., Dr. Stamey received his medical degree at George Washington University, Washington, D.C., and served his internship at Lancaster General Hospital.



You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME
The Network
for Continuing
Medical
Education

NCME TV Offers These Practical Benefits:

- ☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.
- ☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.
- ☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including:
 - Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.
- ☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.
- ☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N. Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N. Y. 10017

An anorectic will help her lose weight—
but can she keep it off?
You need more than a pill
(even ours) to do that!



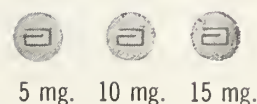
That's why Abbott offers
you a pill plus a program.



The Product

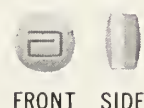
*For smooth appetite
control plus mood
elevation*

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

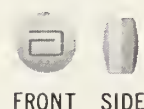


*For patients who can't
take plain amphetamine*

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Portion Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



*Please see Brief Summary
on next page.*

Ask Your Abbott Man For Free Supplies

801444

Brief Summary

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society
in recent months:

BERKS COUNTY:

NICHOLAS T. AGOURIDIS, M.D., 250 N. 12th St., Reading, 19604.

JOHN R. LOUGHEAD, JR., M.D., 620 Walnut St., Reading, 19601.

SAMUAL C. SLIMMER, JR., M.D., Reading Hospital, Reading, 19602.

PAUL K. NASE, M.D., 206 South Sixth Avenue, West Reading, 19602.

WILLIAM B. PRATT, M.D., 1500 Penn Avenue, Wyomissing, 18610.

JOHN S. BARRETT, M.D., South Fifth Avenue at Chestnut, West Reading, 19602.

BRADFORD COUNTY:

JANET SY, M.D., 119 Elm St., Waverly, N.Y.

BUCKS COUNTY:

LOUIS J. CASALE, M.D., 403 South Main St., Doylestown, 18901.

MILTON A. SCHWARTZ, M.D., 85 Makefield Road, Morrisville, 19067.

CENTRE COUNTY:

HARRY M. McDERMOTT, M.D., 720 Waverly Pkwy., State College, 18601.

CHESTER COUNTY:

ROBERT E. ROWAND, M.D., E. I. du Pont de Nemours & Co., Wilmington, Delaware 19898.

WILLIAM J. BARRY, M.D., Chester County Hospital, West Chester, 19380.

MAURY HOBERMAN, M.D., 500 Rosedale Avenue, West Chester, 19380.

DAUPHIN COUNTY:

WILLIAM H. HOWARD, M.D., 2701 N. Front St., Harrisburg, 17110.

DELAWARE COUNTY:

ERNESTO A. ESPINOSA, M.D., Fitzgerald Mercy Hospital, Derby, 19023.

SOLOMON I. LITMAN, M.D., 250 Beverly Blvd., Apt. 200, Upper Darby, 19082.

ARNOLD J. HALPERN, M.D., 705 Elena Dr., Broomall, 19008.

SHELDON L. MORRIS, M.D., 2200 Providence Ave., Chester, 19012.

GERALD RINGOLD, M.D., 2200 Providence Ave., Chester, 19012.

LEBANON COUNTY:

JOHN E. ENGLE, M.D., 322 E. Main St., Palmyra, 17078.

MONTGOMERY COUNTY:

WILLIAM G. STEWART, M.D., Bryn Mawr Medical Bldg.,
Bryn Mawr, 19010.

MONTOUR COUNTY:

MICHAEL J. DALY, JR., M.D., Geisinger Medical Center,
Danville, 17821.

NORTHAMPTON COUNTY:

CARMEN J. GOZUM, M.D., 1724 Maple St., Bethlehem,
18018.

PAUL V. KIEHL, M.D., 1775 Euclid Avenue, Bethlehem,
18018.

LEE R. SATALINE, M.D., 801 Ostrum St., Bethlehem, 18018.

PHILADELPHIA COUNTY:

PACIFICO GERONIMO, M.D., Philadelphia State Hospital,
Philadelphia, 19116.

JACK L. SOLOMON, M.D., 305 Powell Rd., Wynnewood,
19096.

POTTER COUNTY:

FRANCISCO B. VILLA, M.D., 9 West Main Street, Galeton
16922.



DON'T HELP A GOOD BOY GO BAD.
LOCK YOUR CAR. TAKE YOUR KEYS.

NOVEMBER, 1968

*when aging
brings
anguish*

LEPTINOL®

Improvement of mental alertness and awareness in the management of the senility syndrome requires a comforting environment, a stimulating dietary regimen and concomitant drug therapy.

LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses.

LEPTINOL® is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day.

Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.

Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

THE VALE CHEMICAL COMPANY INC.



Pharmaceuticals
Since 1922

ALLENTOWN, PENNSYLVANIA 18102



***"Now that your acne is clearing up nicely,
It might be a good idea if you started losing some weight."***

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain*.

When a new dietary pattern must be established, consider the adjunctive use of **BAMADEX SEQUELS**. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, **BAMADEX SEQUELS** controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients

with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex[®] Sequels[®]

Dextro-Amphetamine Sulfate (15 mg.)
with Meprobamate (300 mg.)

Sustained Release Capsules



LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

407-8



How IMP RTANT is she?

Your
MEDICAL
ASSISTANT

When you think about she does for you, she is most like an extra set hands! On top of all things she now is doing, can help her do a better more efficient job. Encourage her to be active in county, state and national Association of Medical assistants.

Through her county Association of Medical Assistants and the Pennsylvania Association of Medical Assistants your "Gal Friday" can pick up valuable knowledge will assist you and her in everyday work at the office.

Give the Association of Medical Assistants your support for the betterment of your extra set of hands!

OBJECTIVES OF THE ASSOCIATION of MEDICAL ASSISTANTS

To promote self-improvement of its members so that they can better serve the profession. ● To cooperate with the medical profession in improving its public relations. ● To inspire its members to render honest, loyal and efficient service to the profession and the public. ● To stimulate educational services for the betterment of its members.

For Further Information, Write: Pennsylvania Medical Society Council on Public Service



**"Breathing's
a snap again,"
he said
gingerly.
(COMPLIMENTS OF
DIMETAPP)**

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care

to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

Dosage: 1 Extentab morning and evening.

Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A-H-ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.;
phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear
breathing on one tablet

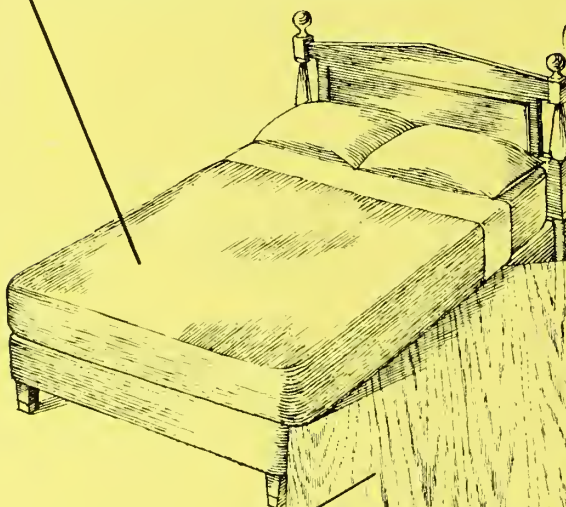


LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

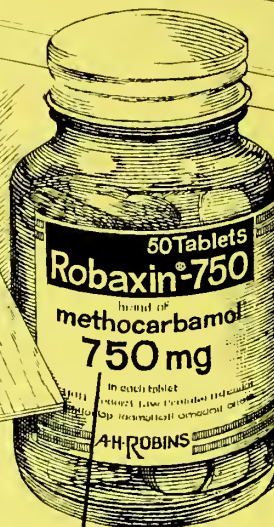
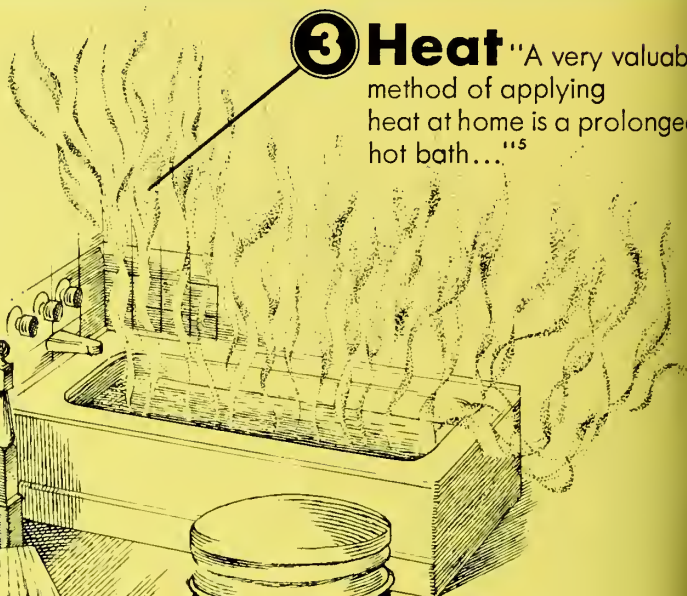
The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.^{1,2} For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:

1 Bed "If the patient is in the pain-spasm-cycle... there is no alternative or substitute for absolute bed rest..."³



2 Board "Boards should be ordered under the mattress... these boards act by immobilizing the spine..."⁴

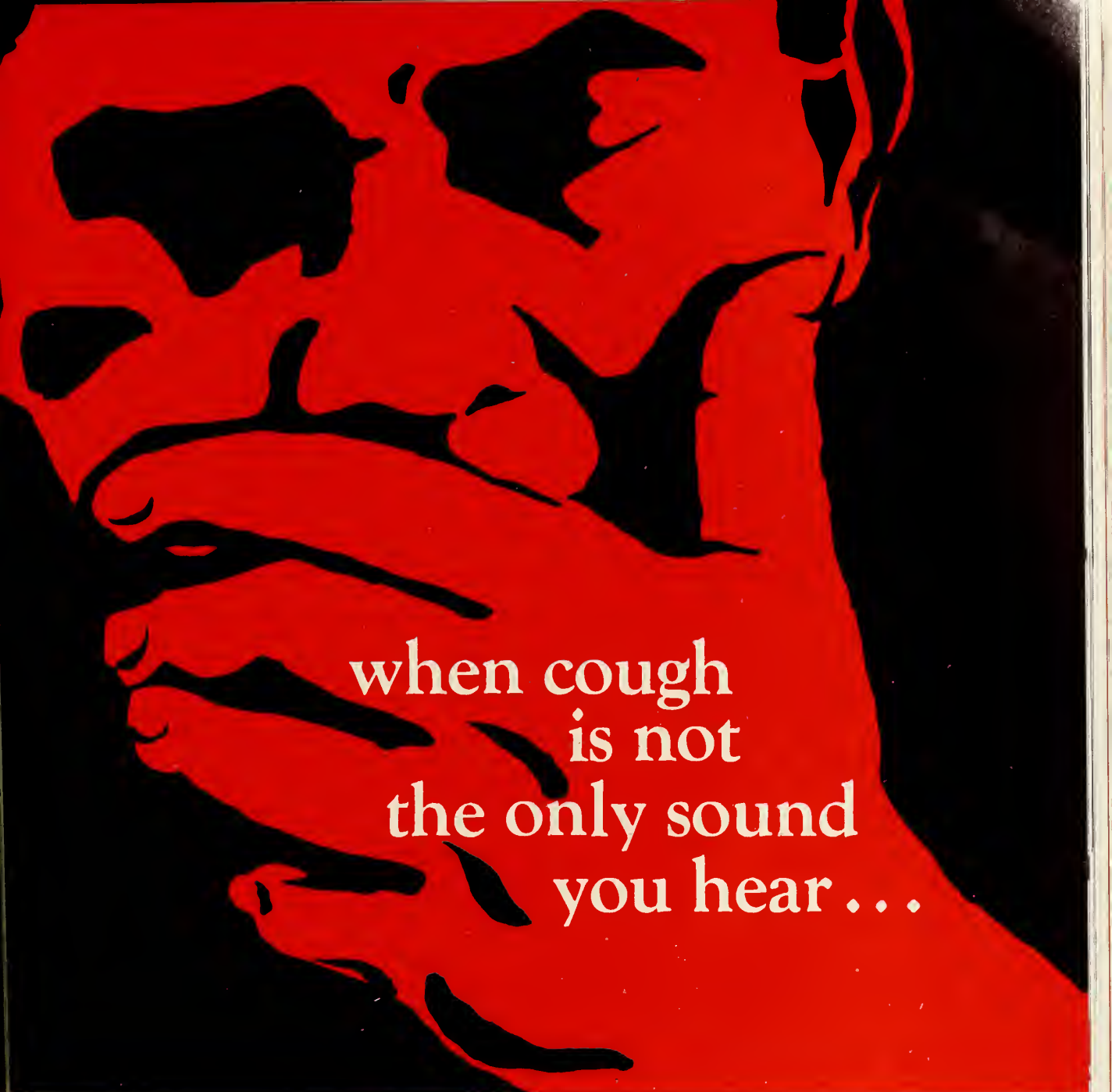
3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."⁵



4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated⁶ skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."⁷ And there is little likelihood of sedation.⁶

Indicated for relief of skeletal muscle spasm. Contraindicated in hypersensitive patients. Side Effects (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. Also available: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)
References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., et al.: New York J. Med. 62:1985, 1962.

A-H-ROBINS A. H. ROBINS COMPANY
RICHMOND, VIRGINIA 23220



when cough
is not
the only sound
you hear...

OMNI-TUSS® b.i.d.

... **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient b.i.d. dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.

Children (6-12 years): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strassenburgh

Strassenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin[®]

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN[®] Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and

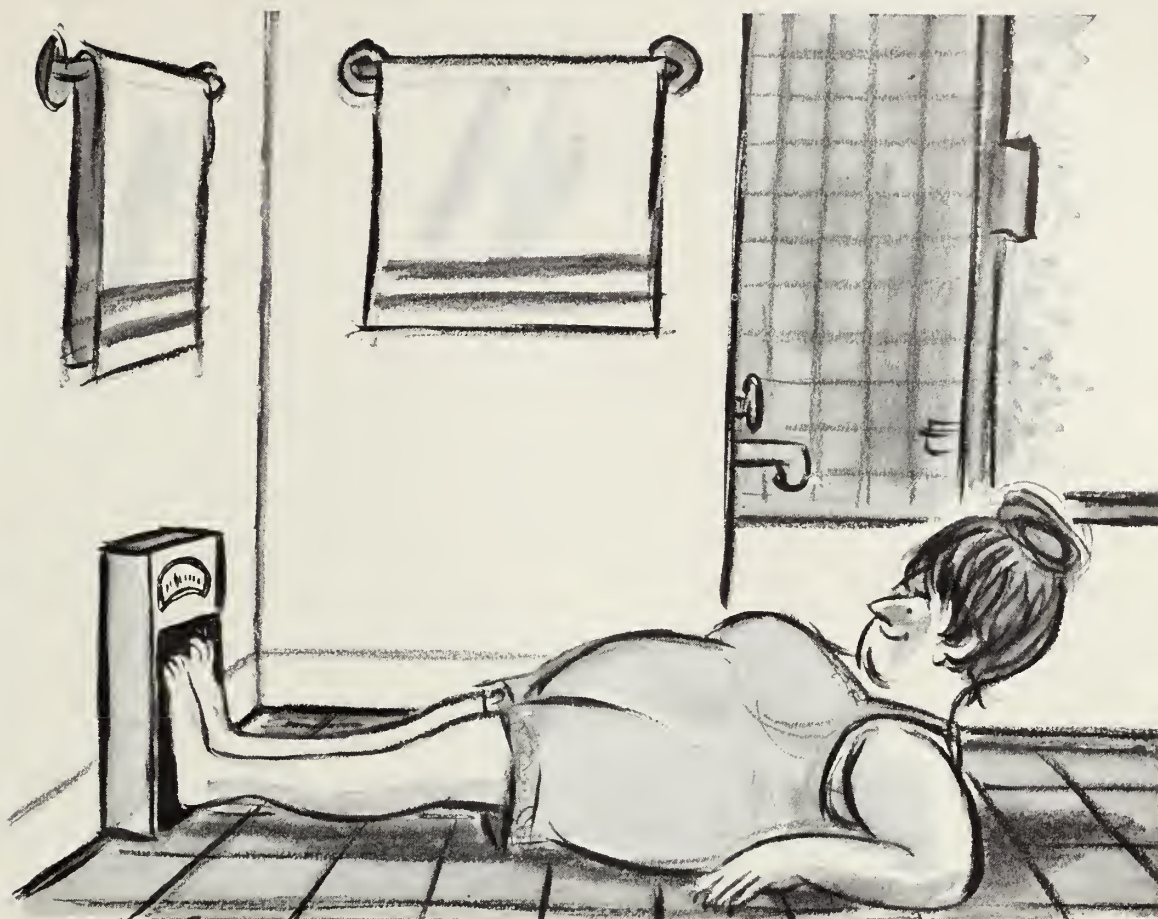
may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



327-8



OBETROL[®] for weight control

Each OBETROL-10 tablet contains: Methamphetamine Saccharate 2.5 mg.; Methamphetamine Hydrochloride 2.5 mg.; Amphetamine Sulfate 2.5 mg.; Dextro-amphetamine Sulfate 2.5 mg.; (OBETROL-20 tablets contain twice this potency) Pat. #2748052.

This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperactive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

Dosage and Administration: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100, 500, and 1000.

REQUEST SAMPLES AND LITERATURE

OBETROL PHARMACEUTICALS • BROOKLYN, N.Y. 11207

DR. _____

ADDRESS _____

CITY _____ STATE _____

SIGNATURE _____

OBETROL PHARMACEUTICALS
Div. of Rexar Pharmacal Corp., Brooklyn, N.Y. 11207



Air Pollution Legislation Signed

*Declaration of Policy ★ Redefinition
of the problem ★ Duties and powers
assigned ★ Changes in the commission
★ Inventory of emissions ★ Rights
to civil action*

Governor Raymond P. Shafer became the third consecutive Pennsylvania governor to affix his signature to Air Pollution control legislation when he signed House Bill 926 in June.

Key provisions of the new legislation are:

- Declaring the policy of the state to be "to protect the air resources of the Commonwealth to the degree necessary for the (1) protection of the public health, safety and well-being of its citizens; (2) prevention of injury to plant and animal life and safety and to property; (3) protection of the comfort and convenience of the public and the protection of the recreational resources of the Commonwealth; and (4) development, attraction and expansion of industry, commerce and agriculture."

- Redefining air pollution as "any form of contaminant including but not limited to the discharging from stacks, chimneys, openings, buildings, structures, open fires, vehicles, processes, or any other source of any smoke, soot, fly ash, dust, cinders, dirt, noxious or obnoxious acids, fumes, oxides, gases, vapors, toxic or radioactive substances, waste, or any other matter in such place, manner or concentration inimical or which may be inimical to the public health, safety or welfare or which is, or may be, injurious to human, plant, or animal life, or to property, or which unreasonably interferes with the comfortable enjoyment of life or property."

- Setting forth of the duties as well as the powers of the Department of Health as to "Receive and initiate complaints of air pollution and submit such complaints to the association of the air pollution control region in which the air contamination source is located.

"Issue orders to any person causing air pollution. The department may stipulate, in such orders, a time within which compliance shall be effected: Provided, however, That within thirty days of the issuance of such order the person to whom it is issued may appeal to the Commission, in writing, with a copy thereof to the Secretary of Health. After such appeal, the order shall be held in abeyance until the Commission shall have granted the person appealing the order reasonable notice and an opportunity to be heard. Thereafter the adjudication of the Commission shall be the order of the department, unless such adjudication is disturbed on appeal. If the person against whom an order of the department is issued fails to appeal to the Commission within thirty days of the issuance of said

order, he shall have waived his right of appeal to the Commission, under this act, or to the courts.

"Institute, in a court of competent jurisdiction proceedings to compel compliance with any order of the department from which there has been no appeal or which has been sustained on appeal.

"Institute prosecutions under this act.

"Require the submission of, and consider for approval, plans and specifications of air pollution control equipment, devices or process changes, and inspect such installations or modifications to insure compliance with the plans which have been approved."

(This section of the amendments has the effect of transferring many of the former duties of the Air Pollution Commission to the Department of Health. This permits the commission to direct more of its efforts to the development of regulations and program policy.)

- Changing the composition of the Air Pollution Commission by eliminating the Secretary of Labor and Industry as an ex-officio member and adding the Secretary of the Department of Community Affairs. It also reduces the number of members to be appointed from "engineers from industry active and experienced in air pollution control" from three to two. One other member shall be a duly licensed professional engineer and two other members shall be members of groups or organizations concerned with the conservation of natural resources in the Commonwealth. The sixth member to be appointed by the Governor will be a member of the general public.

- Providing for, by rule or regulation, an inventory of all air pollution emissions in the Commonwealth, including the locations, sizes and heights of all air contaminant outlets, and including processes employed, fuels used and the nature and time periods or duration of the emissions.

Reducing from six months to three months the time allowed the Regional Air Pollution Associations for the disposition of complaints before them.

- Setting forth more clearly the rights of those affected by air pollution condition to take civil action directly against the interests causing the pollution.

The new legislation is in the form of an amendment to the state's original Air Pollution Control Act signed in late 1960 by the late Governor David L. Lawrence. The original act was also amended by other legislation signed in January, 1966 by former Governor William W. Scranton.

Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action — analgesic, decongestant and antihistaminic — is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, Influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults — 2 tablets every 4 hours.

Children (6-12 years) — 1/2 the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

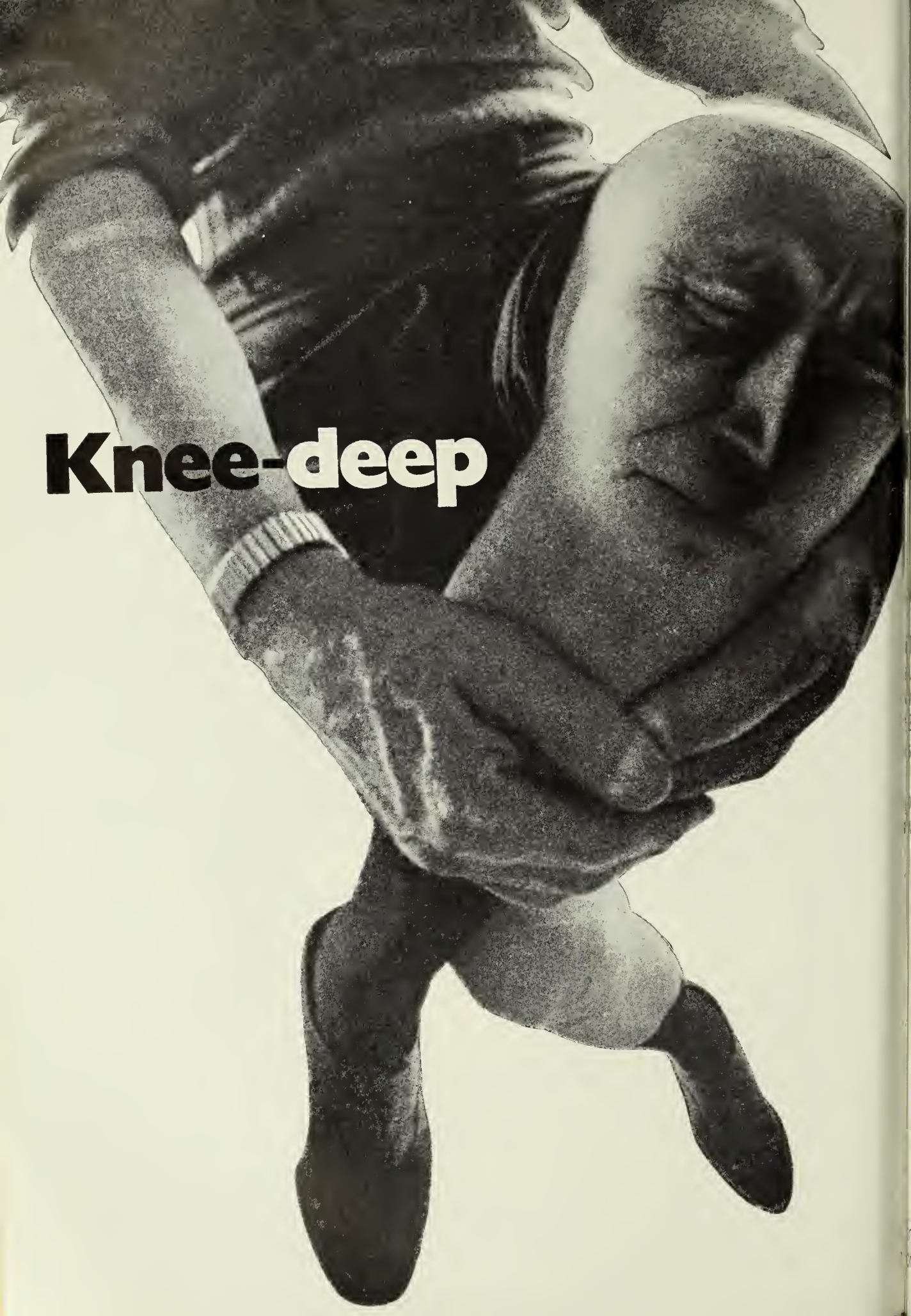
Source of Symptomatic Relief

Sinutab® | 2 tabs. q.4h.



WARNER-CHILCOTT

MORRIS PLAINS, N.J.



Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.

It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil[®]
oxyphenbutazone



Tandearil®

oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discon-

tinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

 Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



Immunizing Against Influenza

As in previous years, I am being asked by physicians about immunizing their patients against influenza by the intracutaneous method advocated by me prior to the 1957 epidemic when the vaccine was in short supply. Recently, the Public Health Service Advisory Committee on Immunization Practices warned that influenza may occur in the United States during the 1968-1969 season resulting from infection with a new strain of influenza A₂ virus. The latter was isolated during a severe influenza epidemic which took place in Hong Kong during July, 1968. Although this new strain cross-reacted somewhat with some previous A₂ strains, there was sufficiently marked antigenic variation to produce disease even in individuals previously immunized against the older A₂ strains. The health officials point out that the present vaccines may provide only limited protection against A₂ (Hong Kong) 68; also that it would take too long to prepare a vaccine from these strains; nor could enough be prepared in time to be of value. They recommend, therefore, that the present bivalent or polyvalent vaccine (containing A₂) be given to high-risk individuals such as persons above 45 and especially over 65; also those with chronic debilitating diseases (cardio-vascular, bronchopulmonary, renal, or metabolic). They suggest that those immunized since July 1963 be given a single booster dose, preferably in early December, a month prior to the usual influenza season. Others should receive a second dose 2 to 4 weeks later. As before, they recommend that adults and children more than 10 years old be given 1.0 ml. subcutaneously; children 6 to 10 0.5 ml.; and children 3 months to 6 years, 0.1 to 0.2 ml. on two occasions 1 to 2 weeks apart followed by a third dose, 0.1 to 0.2 ml., about 2 months later. They recognize that marked local and at times systemic reactions may follow in some individuals and suggest using an antipyretic to control the fever. Nothing is said, however, about the possibility that individuals immunized in this fashion may be made quite ill from such reactions so that industrial workers may be incapacitated and kept from their jobs for one or more days. Such discomfort and time loss, I believe, can be avoided by administering the vaccine intracutaneously in two doses of 0.1 ml. at 4-week intervals beginning in early December. Extensive clinical experience with this method since 1957 as well as immunologic studies both our own and those of others^{1, 2} have shown that the vaccine given in this manner will produce approximately the same antibody response as when it is given subcutaneously without the distressing constitu-

tional reactions. We have been using this method at Temple University Hospital to immunize all our employees and have had an extremely low incidence of systemic effects compared with that which may follow the subcutaneous method.

While the Health Authorities recommend that the vaccine be given to older people and high-risk individuals, many others including industrial workers in many plants will be given the vaccine so as to protect them in the event of an epidemic. In view of the fact that a new vaccine containing the new A₂ virus will not be available to most physicians, and since we are not sure that there will be an epidemic of influenza this year, it would seem wiser and safer to utilize the intracutaneous method of immunization in the manner suggested to avoid incapacitating reactions, especially in industrial workers.

Incidentally, I should like to clear up a misconception regarding the administration of the vaccine to individuals allergic to egg. Because of early reports of reactions to virus vaccines occurring presumably among egg-sensitive children, the vaccine package inserts contain a warning that these vaccines should not be given to egg-sensitive individuals because of a possible reaction. Many physicians therefore do not give these vaccines to patients with a history of egg allergy, even though the latter diagnosis was based upon a positive skin test rather than upon clinical evidence. Since a positive skin test reaction to egg sometimes may be due to past clinical sensitivity (e.g., as in infancy) and not always to existing clinical allergy, it should be verified before considering it significant. If the patient is eating eggs without difficulty, there is no danger of allergic reaction from administration of these vaccines and one should not hesitate to give them. Furthermore, very recently, Kamin and his co-workers³ reported the administration of the live measles vaccine in regular dosage to 22 children with proved allergy to egg, without any ensuing reaction. In addition, they reported that among many allergists and pediatricians to whom they sent questionnaires inquiring about reactions, none reported any. It seems likely that such vaccines contain insufficient egg protein to constitute a hazard to their administration, perhaps, as suggested by Glaser⁴, because the fibroblasts in which the tissue is cultured does not contain egg allergens. In the absence of definite evidence that egg-allergy is responsible for reactions to vaccines prepared in the chick-embryo, one should not hesitate to administer such antigens whenever essential. If such immunization is attempted in the latter individuals, as for example

with influenza vaccine, the intracutaneous method is definitely to be preferred to the subcutaneous route whenever possible.

BIBLIOGRAPHY

1. Saslav, S., Carlisle, H. N. and Perkins, R. L.: Effect of dosage and influenza vaccine content on antibody response in aged population. *Am. J. Med. Sc.*, 251: 195 (Feb.) 1966.
2. Clark, M. L., Reinhardt, H., Muller, M. D. III, and

Wisson, R.: Polyvalent influenza vaccine: Comparison of jet injection with intradermal and subcutaneous syringe methods of administration. *J. Lab. & Clin. Med.* 66: 34, 1965.

3. Kamin, P. B., Fein, B. T., and Britton, H. A.: Live measles vaccine in children allergic to egg, *JAMA*, 193: 1125, 1965.

4. Glaser, J.: Personal communication, International Correspondence Society of Allergists, 27: 43, 1964.

LOUIS TUFT, M.D.
Philadelphia

The High Cost of Medical Care

We read many reports of the rapid increase in the cost of medical care, mostly about increasing hospital costs and rising physicians' fees. These reports come from a variety of groups and agencies. The most vitriolic of late has been from the federal government. After one year of Medicare and Medicaid, when the costs exceeded the government's estimate by over one billion dollars, some scapegoats must be located. Strangely enough, the AMA had assured the Congress that the cost would be much higher than the HEW estimates.

The handiest culprits are the hospitals and physicians. No amount of explanation of why these increases in cost occurred carries any weight. The President says costs must be reduced and others repeatedly say that doctors are increasing their charges shamefully. At the same time, the political leaders continue to raise the minimum wage scale as well as insisting upon the best medical care for all.

However much we as physicians resent all this political fanfare, we do have a responsibility to keep hospital and physicians' costs at as low a level as is reasonably possible. There are many ways that we can reduce these costs.

1. We should be sure that the hospital admission is a necessity for the patient, and not a convenience for the physician. As a radiologist with many years of practice, I can testify that even before Medicare many hospital admissions were either for the convenience of the physician or for the financial advantage of the patient. Hospital insurance programs have contended with this problem for years.

2. As physicians we should advocate that hospital insurance programs provide a mechanism by which all laboratory tests and examinations could be done on an out-patient basis before the patient is admitted. Many times at least two hospital days could be saved if such a program were adopted.

3. Physicians should encourage hospitals to operate on a six, and possible seven, day per week schedule. Plans such as this would eliminate ad-

mitting a patient on Friday for surgery when the operating room is closed on Saturday and Sunday except for emergencies.

4. I think that many diagnostic procedures on the aged are of no value to the patients. They may be of scientific value or interest to the physician. Again, as a radiologist I am asked to make extensive examinations on poor, old, feeble and emaciated patients who are very close to the end of their life, upon whom definitive procedures could not possibly be done even if pathology were found. When I mildly raise the question of the value of some of these procedures, frequently the reply is "Go ahead, Medicare will pay for it." I look back upon the early days of my practice when pneumonia was called the "friend of the aged." Now with all the scientific advances and Medicare, the aged have no friendly disease to carry them out of this world.

I think physicians should give serious consideration to any advancement of fees. What with Medicare and Medicaid, we are being paid a reasonable fee for care of patients who paid us little, or nothing, before. The increased prosperity of our times has increased the volume of our practice and thus our income is greatly increased at even the fees of five years ago.

The basic problem in the matter of increase in fees and hence the increase in physicians' income is: How much income is adequate? It is \$20,000, \$40,000, \$50,000, or \$100,000 per year? I do not have an answer to this question. I am sure, as more and more of physicians' income is derived from third party payments, that a reasonable answer to this question must be determined.

I have no doubt that this article will bring cries of disapproval, but I have deep concern about the future of the practice of medicine and I think physicians should be reminded of their responsibility of keeping medical costs as low as reasonably possible.

JOHN H. HARRIS, M.D.
Harrisburg

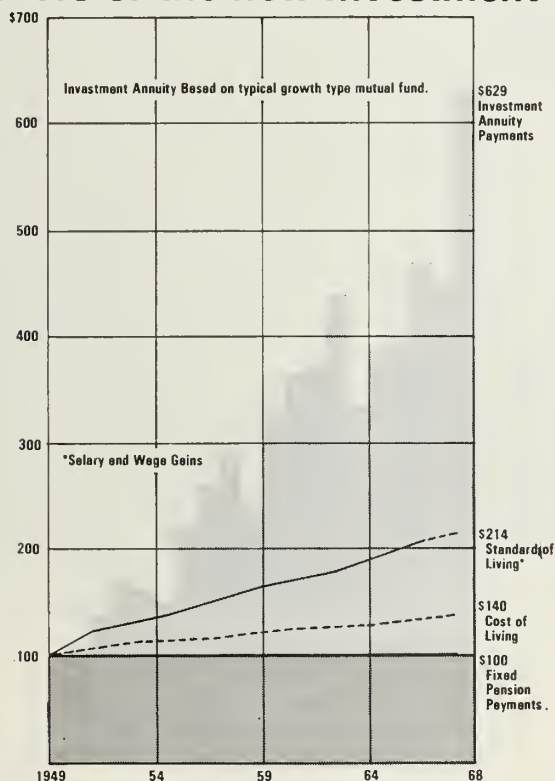
CORRECTION

In the editorial "The Increasing Cost of Medical Care" by William A. Limberger, M.D., of West Chester, which appeared in the September 1968 issue of *Pennsylvania Medicine*, the Journal reported in error in the fifth paragraph: "of the 33 1/3 percent increase, 27 cents or 90 percent of the increase is alleged to be due to increased physicians' fees."

The "90 percent" figure should have read "9 percent" which is the proportion of the 33 1/3 percent increase due to physicians' fees.



With an Investment Annuity, you can s - t - r - e - t - c - h the benefits of your tax-favored retirement plan by your personal control in the selection of growth-oriented investments. ***Educators and Employees of hospitals, churches, charities and other tax-exempt 501 (c)(3) organizations: Does your tax-deferred annuity provide the flexibility and other attributes of the new Investment Annuity?***



This chart is an historical illustration of what the Investment Annuity retirement income benefits would have been if they had started at \$100 per month in 1949, if the retiree's account had been invested in a typical growth-type mutual fund. The chart reflects the increasing market over the past 20 years; it is not to be construed as a forecast for the future.

1. You or your chosen Investment Advisor may select the investments within a tax-sheltered annuity fund Account held by a custodian.
2. Investment changes within your personal Account may be made freely, without incurring tax on income, or on short-term or long-term gains.
3. Benefits vary each year to reflect the investment performance of your personal Account.
4. Benefits may be guaranteed to last for life or on a joint and survivor basis, with payments guaranteed for 5, 10, or 15 years in any event.
5. Benefits for survivors can be increased with FIAC's optional low-cost one-year term insurance to provide growth-oriented, tax-favored lifetime income for your beneficiary.

If you would like to receive a free, 12-page detailed booklet and enrollment forms, mail the coupon today.



FIRST INVESTMENT ANNUITY COMPANY OF AMERICA
1500 Chestnut Street, Philadelphia, Pennsylvania 19102

Name _____ (PM)

Address _____

City _____ State _____ Zip _____

Title or Occupation _____

Employer's Name _____

It's almost as if you were there to give an injection of penicillin



dependable oral penicillin therapy **V-Cillin K[®], Pediatric** Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin[®] (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K[®] (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

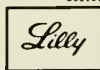
V-Cillin K[®] (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful).

[042567A]

800197

Additional information available
to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206





Rehabilitation of the Cancer Patient

by
JACK M. ZISLIS, M.D.
Philadelphia

*Contribution of
rehabilitation to the
patient and disability
resulting from cancer or
from its treatment*

Although the primary problems of cancer center around early detection and definitive medical and surgical care, the sheer size of the problem of cancer results in significant implications for rehabilitation. Cancer is the second leading cause of death in the United States, ranking only behind cardio-vascular-renal diseases. It is estimated that almost 1 million persons in the United States are presently under treatment for cancer, and about a half million new cancer cases are diagnosed for the first time annually.

Among these cancer patients are those suffering from radical mastectomy, enterostomy, amputation, or laryngectomy for whom the component disciplines of rehabilitation can make a specific contribution.

Rehabilitation can also make a secondary and supporting contribution

to other cancer patients through occupational therapy, social work, psychological services, and recreation when those components within a hospital are provided under the rehabilitation service.

The concept of rehabilitation as it applies to the cancer patient is to produce the maximal restoration and efficiency of function that the individual is capable of achieving. Even though the long term prognosis may be poor, this approach can provide the patient with the maximum degree of function, comfort, and usefulness to himself and his family. Also there is the added benefit and reassurance that something can be done for the patient, affording him a measure of hope for the future. This, rather than the development of a pessimistic do-nothing attitude, where steady decompensation,

attrition, debility, deformity and psychological upheaval are allowed to overwhelm the patient.

Rehabilitation medicine accompanies the care of the patient by the chemotherapist, neurologist, and surgeon, and serves to support the measures being taken by them to save the patient's life. It then projects possibilities of helping the patient achieve maximal comfort and minimizes the physical disability resulting from the impairment which they have sustained as a result of the malignancy or its surgical removal. In addition to consideration of the medical-surgical status of the patient the rehabilitation evaluation should include an estimate of the mental attitude of the patient and his ability to understand instructions and cooperate. For example, in neoplasm in the cerebrum the patient may have impairment of memory, comprehension, and learning ability. Training in these instances demands highly structured, simple instructions that are repeated frequently. Often psychological testing is helpful in evaluating the patient's intellectual performance and this adds further information needed in psychiatric support and counseling, as well as aiding the therapist in approaching treatment techniques.

Also to be evaluated is the range of motion of the limbs, trunk, head and neck. It is quite common for cancer patients to develop decreasing range of motion of joints and ultimately contracture deformity due to decreasing activity, prolonged bed rest, and local involvement by neoplasm. This is particularly common in the hip and knee joints where flexion contractures develop and also in shoulder joints where restriction frequently develops in abduction and external rotation.

Thoracic surgery for malignancy frequently results in shoulder girdle and thoracic muscular weakness and imbalance—issuing from the necessary surgery as well as resultant pain and protective muscle spasm. Life-saving amputations for malignancy including limbs as well as breast cancer have their own residua in limitation of adjacent joint motion. In radical breast surgery, as well as thoracic surgery, a not uncommon lesion is frozen shoulder. Neurological disturbances whether they be of upper motor neuron type, lower motor neuron, or myopathic disturbances may have their counterpart of limited joint function with progressive limited range of motion and deformity if unattended.

After evaluating and recording the range of motion values, efforts should be directed to correct any limitations. Of course prevention would be far more satisfactory and can often be accomplished by instructing the patient in an appropriate exercise program prior to surgery which is carried out faithfully after surgery and at times indefinitely. Range of motion may be protected by adequate positioning of the patient in bed, careful use of sandbags and the use of posterior leg splints

It is common for cancer patients to develop decreasing range of motion of joints and ultimately contracture deformity due to decreasing activity, prolonged bed rest, and local involvement of neoplasm.

and foot boards. Range of motion exercise can be carried out by a physical and occupational therapist. These may be passive exercises where the therapist carries the extremity through its range of motion, or active-assistance to active exercises, where the bed patient carries the extremity through range of motion as much as possible and the therapist helps complete the range of motion, and active exercises where the patient carries the joint through the range of motion entirely

on his own power. The therapist can add counter resistance for resistive exercise. Two accomplishments are achieved here. The maintenance of normal range of motion or the regaining of range of motion when deficient can be achieved. Also weakened muscles may be strengthened to attain optimum motor function.

Nervous system disturbances may be manifested by varying degrees of flaccid type of paralysis in lower motor neuron impairment, resulting from direct encroachment by tumor or peripheral nerves or nerve roots. Carcinoma not infrequently can be associated with neuropathy, myopathy or neuromyopathy. Electromyography, conduction velocity studies of peripheral nerves, and strength-duration electrodiagnostic testing may be useful in discerning the presence of these associated disorders. Galvanic electrotherapy is useful in applying electrical stimulation to muscles that suffer partial to complete denervation, faradic stimulation being used where nerve degeneration has not occurred. Electrical stimulation is useful in maintaining normal skeletal fiber diameter, retarding development of muscle atrophy, and in muscle re-education. It is useful as an accompaniment to passive range of motion until sufficient motor power returns so that active exercise can be carried out.

Early efforts should be made to resist generalized debilitation in cancer patients who need prolonged bed rest as part of their management. It is well known that negative nitrogen balance, negative calcium balance, nephrocalcinosis, urinary tract infection, thrombophlebitis, vascular occlusions, pulmonary embolism, loss of vasomotor tone, increase incidence of pulmonary infection and many other serious complications can result from prolonged inactivity. The use of a tilt table can gradually accustom the patient to vertical positions and be one step toward early ambulation procedures, at the same time resisting the disastrous effects of prolonged immobility.

Evaluation of each patient's function is also carried out in terms of ability to carry out activities of daily living such as toileting, bathing, dressing, feeding, ability to transfer to and from bed, wheelchair, chairs, to standing position. Ambulation is evaluated. The capability of the patient in terms of motor strength, joint range of motion, coordination, and the need for appro-

Many physical modalities are available

appropriate splinting or bracing are assessed.

In tumors resulting in Stroke Syndrome, efforts initially are made to maintain normal range of motion of joints by positioning and exercise. Selective muscle re-education is the next step in the physical restoration phase of the rehabilitation program. It is initiated as soon as voluntary movement becomes manifest and should be continued as long as improvement takes place. An attempt should be made to develop flexor and extensor groups equally in both the upper and lower extremities. This is difficult because as spasticity develops there is a tendency to flexor spasticity in the upper extremity and extensor spasticity in the lower extremity. In muscle re-education stress should be placed on function—not merely restoration of motor power. As soon as the patient is able to sit up in bed with assistance he should be started on a program of sitting balance, then later, standing balance. The progress which the patient makes will determine the rapidity with which standing balance can be initiated. It is usually initiated at the bedside with someone standing next to the patient's paretic side. When the patient is unable to stand with assistance, it is often helpful to start standing balance with a tilt board. Standing balance can be continued between parallel bars, if these are available. As soon as this is mastered, ambulation training should be started. Sitting and standing balance may develop slowly, particularly in elderly hemiparetic patients. It is advisable to have such patients rise slowly and to pause following a change from supine to sitting position or sitting to standing position. Also, they should have a solid object near by so that they may grasp it and maintain balance when first standing. Quick head turning should also be avoided when the patient is in the erect position because of impaired postural reflexes and a tendency of this maneuver to cause loss of balance.

Initial ambulation training is carried out under close supervision or assistance with parallel bars and efforts are made to develop a reciprocal walking pattern. Often it is necessary for the patient to adopt a gait which is not normal because of persistent muscular weakness or spasticity. Under these circumstances he should be taught the

gait which is safest for him rather than a gait which has the most normal appearance. If supination of the foot occurs with hip and knee flexion and the gait is unstable, a short leg brace may be needed to correct this and permit the fairly rapid learning of a normal gait pattern. The patient progresses from parallel bars to walking outside the bars with assistance of the therapist, and then progresses to no assistance other than possibly the use of a cane in the normal hand. When the patient has mastered independent ambulation on a level surface, ascending and descending curbs, ramps and stairs should be taught. Bracing can be employed for stabilization, support, pain relief, and protection of diseased joints. If the patient is ambulatory, a gait analysis is carried out to observe aberration of gait and a plan is initiated to correct it if possible to make the gait as safe as possible and protect remaining functioning muscles and joints.

These factors certainly are pertinent in malignancy affecting upper and/or lower motor nerve function. Once the individual patient's needs are assessed, therapy directed toward joint mobilization, strengthening of appropriate musculature, and the prescription of required bracing is made. Rehabilitation team conferences including the various members, such as physical therapy, occupational therapy, activities of daily living nursing, psychology and social service should discuss periodically the case to assess progress and project future goals for the patient set within a framework of realistic feasibility.

Many physical modalities are available to the rehabilitation physician in order to expedite the achievement of goals that are set for the patient. The cancer patient may have skin ulcerations or may have painful muscles. Hydrotherapy can be applied for the benefit of heat to raise pain threshold locally and relax muscles. With agitation it can be used to debride superficial ulcerations. A patient in early phases of ambulation may benefit from underwater exercises in a Hubbard tank for muscle strengthening, coordination and range of motion. The therapeutic pool also can be used for this purpose but has an additional advantage in that the patient who is allowed only partial weight bearing or

who needs some compression to legs for deep venous disease and edema can walk in water of sufficient depth to provide the deep pressure and buoyancy necessary to achieve these therapeutic effects.

Ultrasound is another useful physical modality for application of deep heat, particularly in post-mastectomy patients with frozen shoulder. Here the deep heat will increase the local circulation near the bone and help dissolution of calcium salts, relief of pain and free joint for mobilization. The physical therapist can instruct the patient in Codman exercises, shoulder wheel and finger ladder activities which are also useful in re-establishing scapulothoracic and glenohumoral motion.

Many patients with malignancy resulting in neurogenic disease or myopathy need special training to re-establish maximal capability of function of upper extremities. The occupational therapist directs the patient in activities that will augment skills of activities of daily living. Functional capabilities requiring manual dexterity will help increase strength of upper limb musculature. Occupational therapy can also provide psychological supportive activities. The patient can be given tasks not only directed toward self-care achievement but which can be given at a standing table to further increase patient's overall physical endurance and standing tolerance. The loom, printing press, and reciprocal sander are only a few examples of devices that the occupational therapist can employ in improving range of motion, increasing motor power and developing the patient's exercise tolerance.

A special kitchen area is employed in training the patient who has difficulty in ambulation or in using upper extremities in meal preparation and other homemaking activities. A skilled occupational therapist can fabricate special functional splints in order to regain maximal grasping ability in a weakened or deformed hand, and simultaneously to protect it against further deformity. Self-help devices are employed to make dressing, feeding and homemaking possible if not easier.

Not infrequently the presence of a malignancy necessitates the amputation of a limb in order to save the pa-

tient's life. It should be emphasized that every effort must be made to prepare the patient for this event psychologically. The surgery must be carried out with a consideration as to the best level for fitting a prosthesis if this be possible. Careful surgical technique to produce a good stump can also contribute to the successful training of the patient with a prosthesis. Attention to maintenance of normal range of motion of residual joints and strengthening of controlling musculature in accompaniment to stump conditioning are also necessary prior to fitting the patient with his permanent prosthesis. It is important to realize the various steps in the rehabilitation management of the amputee. When carried out to the fullest usually an individual can regain the facility of ambulation or the use of an artificial arm in fulfilling personal needs and even in many instances can regain economic independence and a sense of fulfillment and self respect.

Radical mastectomy is often the treatment for breast cancer. The loss of a breast is a major emotional and physical catastrophe to a woman. The physician's reassurances, based upon unhurried examination, and his interest in the cosmetic, emotional, and social problems will be appreciated. The patient should know before surgery that she may require a mastectomy, and exercises may be profitably taught pre-operatively. Continuing psychological support should begin at this time. Post-operatively, the physical program is devoted to prevention of contractures about the shoulder and of lymphedema of the homolateral arm. The postoperative exercises aim to secure a complete range of motion of the shoulder joint in the absence of the pectoralis major muscle and to maintain the extremes of flexion, abduction, horizontal abduction, and external and internal rotation. If this is properly done, muscle power also will be maintained. The formal exercises lead naturally into the normal functional activities of daily life such as brushing the hair, and reaching to high shelves. The use of the homolateral arm for these purposes should, of course, be encouraged. Correct posture should be practiced in front of a full length mirror until it becomes habitual.

Lymphedema is probably the most incapacitating secondary disability, leading to numbness, aching or pain, disfigurement and uselessness of the

arm. However, disability may not necessarily be proportionate to the degree of edema and may be present even in the total absence of edema. The key to prevention of lymphedema probably lies in the surgical technique which unfortunately is seldom elective. Disability and swelling can probably be best prevented by early mobilization of the arm through a graded exercise program leading to active functional use of the member. Intermittent elevation and the use of an elastic sleeve or bandage may also have prophylactic value. A wide selection of inexpensive cosmetic replacements, many of which realistically change their contour with body and arm movements, is available in many women's specialty stores. Clothing and beach styles are easily adapted with ruffles, capes and inserts to compensate further for asymmetry. Before the patient leaves the hospital a temporary filler should be provided for use until a permanent device may be worn.

Malignancy involving the gastrointestinal tract often requires the employment of an enterostomy in surgical management. The rehabilitation of the patient who has had an enterostomy includes training in the control of elimination and in the care of the stoma as well as psychological counseling. If these interdependent areas are adequately managed, social and vocational problems will be minimized. It is wise to advise the patient



■ Dr. Zisli is associate professor of physical medicine and rehabilitation at Temple University School of Medicine and director of patient care for the RT-8 Center and Moss Rehabilitation Center.

of the possibility or probability of his having to have an enterostomy if the operative findings necessitate it and to assure him that under those circumstances it will be a lifesaving measure but that it need not stand in the way of an active productive life. Post-operatively the patient will be more concerned with the long term problems of elimination, family and social relationships, economics and the danger of recurrence of the cancer. In addition to the reaction to chronic, possibly progressive, disability per se, he must adjust to the unpleasant chores of care of the stoma and of elimination to achieve social confidence in the face of the hazards of spillage and odor. Details of dressings, appliances, diets and irrigations are discussed in many publications. The most essential ingredient of the program is training the patient in their application. Written instructions should be supplemented by individualized personal instruction and demonstration and should be started as early as possible, and repeated until the patient is capable of performing these self-care activities independently.

Cancer of the larynx often necessitates surgical removal of the larynx. Since the patient cannot phonate and therefore, cannot produce voice after laryngectomy it is urgent that the rehabilitation process must not end with surgery. Esophageal speech, pharyngeal voice, gastric voice and pseudo whisper are forms of speech that may be employed by laryngectomized patients. These terms are derived from the storage sites of air used in producing voice. In addition there are a number of artificial types of larynges. In general specialists in post-laryngectomy speech have felt that mechanical devices should be used only in cases where attempts at pseudo voice have failed.

The purpose of this presentation has been to indicate that the component disciplines of rehabilitation can make a specific rehabilitation contribution with special emphasis on cancer patients who have associated neuromuscular disorders, radical mastectomy, amputation, enterostomy, or laryngectomy.

Acknowledgment

The material in this paper was made possible through grant No. RT-8 to Temple University School of Medicine by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare.

*Report
of a
Case
by*

DANIEL H. BROOKS, M.D.
HORMOZ AZAR, M.D.
RALPH SIEWERS, M.D.
HENRY T. BAHNSON, M.D.
Pittsburgh



Human Heart Transplantation

SINCE Alexis Carrel,¹ in 1905, reported the successful transplantation of a heart from one dog to the neck of another dog, surgeons have searched for a way to treat irreversible heart disease by heart transplantation. In 1933 Mann² reported an eight day survival using the Carrel technique. The dog's death was attributed to homograft rejection. In 1953 Marcus, Wong, and Luisada³ transplanted the donor heart and lungs into the recipient dog's abdomen, and suggested that this might be a clinically successful technique. The most important technical advance was made by Lower and Shumway⁴ in 1960. They modified a technique described by Goldberg, Berman, and Ahman,⁵ in which the recipient's posterior atria were retained and the graft was sutured directly to the remaining portion of the recipient's heart. Barnard⁶ and

Cooley⁷ have further refined the technique to insure preservation of the sinus node of the donor heart. Management of homograft rejection by immunosuppressive therapy has made possible survival for eight months of Barnard's second patient.

This report describes the transplantation of a human heart.

Case Report

The patient, age forty-six, was admitted to the Presbyterian-University Hospital on June 22, 1968 in severe congestive heart failure. The patient had had chronic heart failure for three years, diagnosed as primary idiopathic cardiomyopathy. There had been a progressive downhill course with interstitial pulmonary edema, anasarca, weakness and cachexia. A coronary angiogram had been normal two years prior to this admission.

The patient was a chronically ill male with a blood pressure of 100/60, pulse 104, Cheyne Stokes respirations, T.37°C and a weight of 70 kg. There were rales at the lung bases. The cardiac rhythm was regular. The left heart border was at the anterior axillary line. There was a parasternal heave, a grade II/VI holosystolic murmur at the apex, and a loud ventricular gallop. The liver was palpable 11 cm. below the right costal margin. The genitalia were edematous, and there was marked pitting edema of the lower extremities.

The electrocardiogram showed left axis deviation and left ventricular hypertrophy and strain. A chest x-ray showed cardiomegaly and a cardiac catheterization showed elevated right atrial, right ventricular, pulmonary artery, and wedge pressures. Pulmonary artery pressure was 45/16 mm Hg.

The left ventricular end diastolic pressure was 18 mm Hg. The findings indicated biventricular failure, with a mild increase in pulmonary artery pressure.

The patient was referred for cardiac transplantation and while waiting for an appropriate donor was maintained on digitalis and ethacrynic acid, with no improvement. The patient was unable to ambulate without severe dyspnea and pulmonary edema.

On August 31, 1968, a twenty-two year old male was brought to Presbyterian-University Hospital Emergency Room four hours after an automobile accident. He was unresponsive, apneic, areflexic, and had no cerebral activity on EEG. After blood types were found compatible, permission was obtained for heart transplantation.

Cardiac action and circulation of the donor were maintained by artificial ventilation and levarterenol. At the appropriate time the heart was quickly excised and placed in Ringer's lactate solution at 4°C. The recipient was placed on cardiopulmonary bypass and his heart was excised. The donor heart was sutured into the recipient as described by Cooley, and perfused after one hour and sixteen minutes of ischemia. The patient was rewarmed and the heart beat spontaneously initially, later fibrillated and was reversed with a single 20 watt second shock. The circulation was well maintained by the graft after an isoproterenol drip (0.5 mg/250 cc 5% D/W) was begun. A nodal rhythm was noted.

Post-operatively, the patient has progressed satisfactorily. The isoprotere-

nol drip was continued for forty-eight hours and gradually withdrawn. Blood pressure was maintained between 100-140 mm. Hg. with a heart rate of 80 per minute. The central venous pressure ranged between 20-28 cm. of saline. On the third post-operative day, cardiac pacing was begun after the nodal rhythm slowed to 50-60 beats per minute. Urine output was normal and negative water balance was maintained for the first four days.

Blood urea nitrogen (BUN), electrolytes, serum glutamic oxaloacetic transaminase (SGOT), LDH, creatine phosphokinase (CPK), glutamic pyruvic transaminase (GPT), and blood gases remained normal. Respiratory support was used for sixteen hours, and the patient was extubated in twenty-four hours. The patient was begun on an immunosuppression regimen consisting of azathioprine, corticosteroids, and antilymphocytic globulin. Digoxin* 0.25 mgms. was given daily. He was kept on mask, gown, and glove isolation probably for twenty-one days.

Oral feedings were begun on the second post-operative day. Progressive ambulation routine was begun on the third post-operative day. At the time of this report, which is the thirty-eighth post-operative day, there have been no complications and no evidence of rejection.

Comment

This patient was an excellent candidate for transplantation because of his progressive, apparently terminal cardiac failure due to myocarditis. Pul-

monary artery pressure was minimally elevated. Aside from cardiac cachexia and muscle wasting, the patient had no other disease.

His post-operative course has been gratifyingly smooth. He began to mobilize edema fluid quickly, and his ankles were less swollen twenty-four hours after the operation. Of considerable interest was the high venous pressure, up to 30 cm. of saline, despite a diuresis and negative water balance and despite the fact that other measurements indicated good cardiac function. The early need for isoproterenol, before the venous pressure was so strikingly elevated, was also interesting and may be related to depletion of catecholamines in the grafted heart, as has been reported by Daggett⁸ in long term observation of canine cardiac autotransplant.

REFERENCES

1. Carrel, A.: The surgery of blood vessels, Johns Hopkins Hospital Bull., 18: 18, 1907.
2. Mann, F. C., Priestly, J. F., Markowitz, J., and Yates, W. M.: Transplantation of the intact mammalian heart, Arch. Surg. 26: 219, 1933.
3. Marcus, E., Wong, S. N. I., Luisada, A.: Homologous heart grafts, Arch. Surg., 66: 179, 1953.
4. Lower, R. R., Shumway, N. E.: Studies on orthotopic transplantation of the canine heart, S. Forum 11: 18, 1960.
5. Goldberg, M., Berman, E. F., Akman, L. C.: Homologous transplantation of the canine heart, J. Intl. Coll. Surg. 30: 575, 1958.
6. Barnard, C. N.: A human cardiac transplant: An interim report of a successful operation performed at Groote Schuur Hospital, Cape-town, South Africa, Med. J. 41: 1271, 1967.
7. Cooley, D. A., Bloodwell, R. D., Hallman, G. L., Nora, J.: Transplantation of the human heart, J.A.M.A., 205: 479, 1968.
8. Daggett, W. M., Willman, V. L., Cooper, T., Hanlon, R. C.: Work capacity and efficiency of the autotransplanted heart, Circ. Supp. 1, P. 1-96, 1967.

* Rexall Drug Company.

THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA

FOUNDED 1824: A chartered university since 1838. Coeducational 1961.

FACILITIES: Jefferson Hall contains modern well-equipped laboratories, the Daniel Baugh Institute of Anatomy, and a student-faculty activities center; Jefferson Medical College Hospital; Curtis Clinic—an outpatient center; Barton Memorial Division of Chest Diseases; teaching museums and libraries; and instruction privileges in sixteen other hospitals.

ADMISSION: For full particulars regarding admission requirements write to Samuel S. Conly, Jr., M.D., Associate Dean and Director of Admissions, 1025 Walnut St., Philadelphia, Pa. 19107.

WILLIAM F. KELLOW, M.D.
Dean and Vice President

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



For headache, a sovereign remedy was to wear a snakeskin round one's head.



The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

**A realistic
approach
to pain
relief**

Empirin[®]

**Compound with Codeine
Phosphate gr. 1/2 No. 3**

Each tablet contains:

Codeine Phosphate gr. 1/2 (Warning—may be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

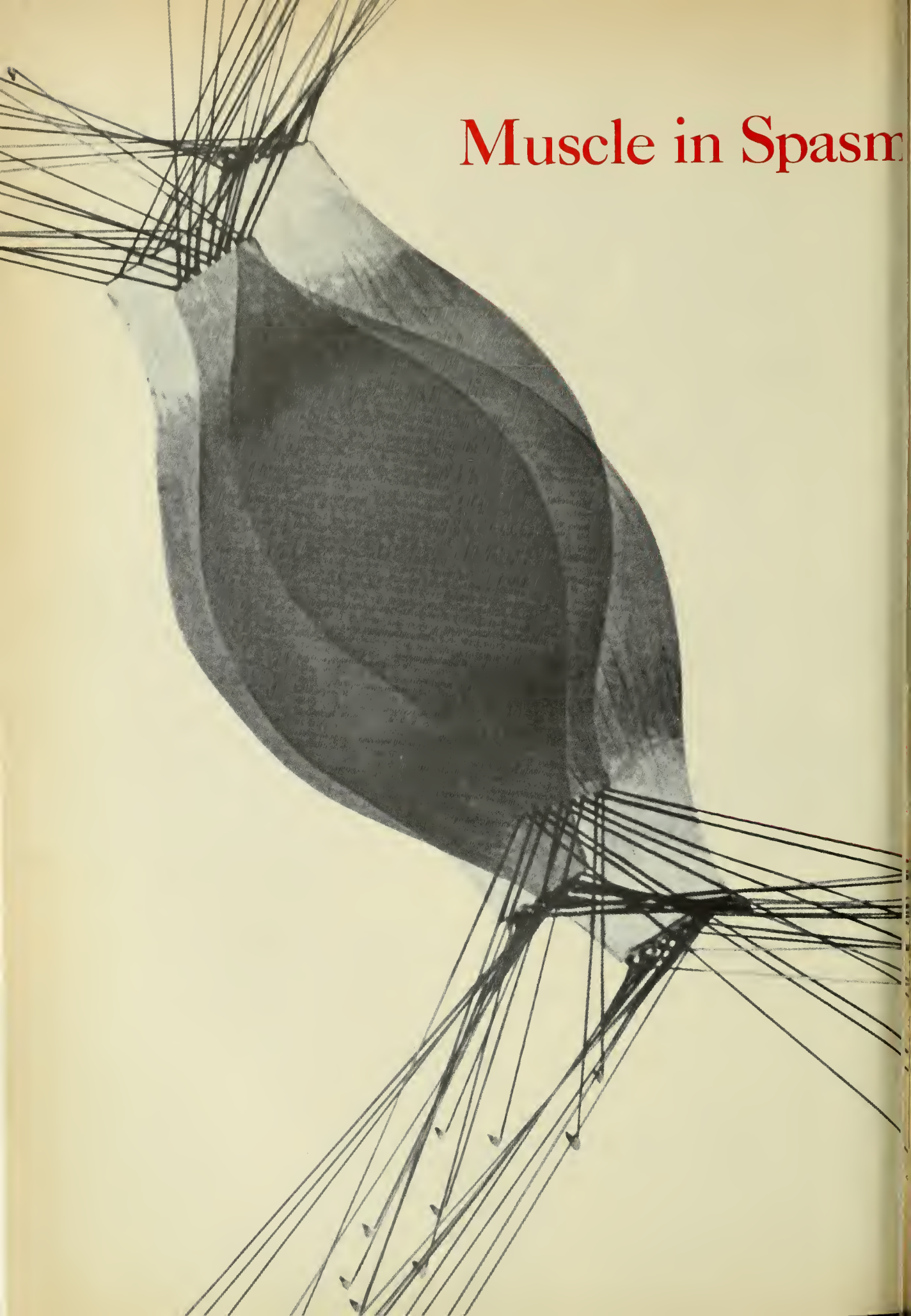
**keeps the promise
of pain relief**

W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

 **BURROUGHS WELLCOME & CO. (U.S.A.) INC.**
Tuckahoe, N.Y.



Muscle in Spasm



and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium[®] (diazepam)
2-mg, 5-mg, 10-mg tablets





A little

Just one 50 or 100 mg tablet in the morning can work a long diuretic day in edema and hypertension.



Hygroton[®] can work a long day too

chlorthalidone

It's because of its prolonged action, which usually provides smooth diuretic activity throughout the day. And once-a-day dosage means few tablets to take and few tablets to pay for in the long run.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

Hygroton
chlorthalidone in edema and hypertension

Geigy



in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypoten-

sion, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rash, urticaria, purpura, necrotizing angitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresis, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 5 mg., in bottles of 100 and 1000. (B)46-230-E

For full details, please see the complete prescribing information.



Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



Photo professionally posed.

No injection after all! This penicillin produces high, fast levels—orally.

Pen-Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN·VEE® K**
(potassium phenoxymethyl penicillin)





Extended Medical Care Facilities

by

JOSEPH T. FREEMAN, M.D., F.A.C.P.

On January 1, 1967 another sector in the growing network of health services under Federal direction was activated. This consisted of the Extended Care Facilities under the Social Security Law of 1935 amended in 1965 to include Medicare. Whereas many important features of Social Security serve a number of interrelated economic, social and medical functions, the Extended Care Facility was designed primarily for *medical* purposes, and the physician is essential to its operation.

It would not be unexpected for preliminary activities in such an important area to be confusing. Nursing homes after enlistment, as an example, had to be accredited to get the program started without delay. These homes have been under pressure in their own right to find a proper place between the need for skilled nursing care and effective residential care. As one elderly lady said, "These places are getting to be too much like a hospital and who wants to live the remaining years of life in a hospital?" Hard on the heels of this shifting balance between health care and social assistance in average living, nursing homes were given some of the obligation of supplying extended health and medical care under very special rules. The table of organization with which to accomplish this end has not had enough time or direction in which to make the objective as firm as the intent.

In the urgency to improve nursing homes and to direct them into proper action under the increasingly stringent regulations that are essential, the trend has been to erase the differences between an institution for the nursing care of elderly ill and homes for the residential care of the old. Most people in nursing and residential homes have passed the age of seventy-five. At least 80 percent of these residents have classifiable diseases. All

of them have depletions of physiological capacities that bear a linear relationship to the age of the group, subject to individual variations.

Institutions other than nursing homes such as hospitals in which Extended Care Facilities belong need time in which to arrange finances and to establish an organization with a suitable capital structure. Lines of authority must be adopted to promote the most effective operation of procedures in this new arrangement that has been interposed between the regular hospital and the nursing home complex. Hasty action, necessary as it seems to be, could raise costs and threaten this important development in the sequence of health care. The goal of the extended type of care must be an ultimate resumption of the previous form of residence for as many individuals as can be made possible.

The nature of extended care is spelled out very precisely as a post-hospital service. In the *Code for Federal Regulation of the Federal Health Insurance for the Aged, Conditions of Participation: Extended Care Facilities*, the new facility is described as

"an intermediate institution which provides post-hospital, subacute services/The hospital is designed to initiate care/The extended care facility is designed to continue care/"

The line between these provisos and those for skilled nursing home service is subject to the requirement that the

"purpose of the extended care benefit is to encourage the most effective and economic utilization of available medical care resources and facilities."

Fine points must be weighed to find a cleavage, for example, between regulations for infirmaries of nursing homes in Pennsylvania (revised and

completed by the Office of Aging, Pennsylvania Department of Public Welfare in 1967) and regulations for extended care facilities under the Federal plan made available in the same year (Table I).

The rules for extended care are clear but there is a chance that they will be manipulated to increase the flow of patients to nursing homes. Instances of misuse and misunderstanding have been recorded. As an example, a physician in Ohio who had been associated with the County Home for the Aged refused to certify certain individuals for care. He was released from his duties. The medical authorities who reviewed the issue said that there was a wide gap between the "meaningful medical review" of utilization and procedure.

One form of improper use is the action of a physician who places a person in the hospital for three days, regardless of needs, in order to comply with this requirement that then permits transfer for twenty to one hundred days of care in a facility at a charge to the patient of \$5.00 per day for each day after the initial twenty days. Another form could be the result of the encroachment of welfare policy on primary medical affairs. The intrusion of procedure such as this can erase the difference between Extended Care Facilities and nursing homes just as differences between nursing homes and domiciliary arrangements have been blurred by regulations that tend to make their operations almost identical. None of these actions are final. Many adjustments are being made and others proposed in this preliminary period.

The rules for Extended Care Facilities are:

- 1) The patient must have been in the hospital for a minimum of three days for any spell of illness, renamed, benefit period

- 2) Admission to the facility must take place within fourteen days of the hospital stay
- 3) Duration of stay consists of twenty days paid for under the Social Security Act and eighty additional days at a cost to the patient of \$5.00 per day. Utilization must be reviewed by physicians after sixty days

The whole concept of extended care revolves around the physician whose obligations have been defined very clearly. He must determine the need for the admission of the patient; arrange for transfer between the hospital and the Extended Care Facility with which it has a formal arrangement; see that a medical record accompanies the patient or is placed on the chart at the receiving institution within forty-eight hours after admission with the understanding that physical evaluations done within the previous two weeks would be acceptable; order the medications and diagnostic procedures, plan for restorative services; prescribe the diet; and supply the medical supervision of the patient. The difference for the ill person going to an Extended Care Facility from a hospital is that the physical condition generally is better than would be the case in a hospital (with allowances such as terminal care) and that more care is planned in an uninterrupted health program from hospital to facility (Diagram I).

Precise evaluation of the manner in which the Extended Care Facility is used is subject to the decision of the Utilization Review Committee composed only of physicians. This is the key to the control of such facilities. These physicians must consist of two persons of whom one shall not be the owner or interested financially in the facility; or, staff members designated by the affiliated hospital, county medical society, state medical society, or other medical faculties that are acceptable to the accreditation authority. Regulations for the regular meeting of the Utilization Committee and the review of charts with notes thereof are essential to comply with the entire plan.

If the medical profession fails to perform its functions in the operation of this important health facility in which the law has sought a definite medical orientation, it will be abandoning a growing segment of important medical care. To meet normal medical obligations before the pro-

gram can become fixed as a welfare function, it is essential for responsible medical groups to establish a network of medical supervision. This could be done readily within the structure of the state medical society and its county society components. Affiliations of hospital staffs and facilities at various regional levels help to guarantee the full application of a medically-oriented law for the Extended Care Facility.

One method of promoting this goal is to change the name from the *Extended Care Facility* to *Extended Medical Care Facility*. The change in terminology is minor but the implications are important. The emphasis in the title should be on the *medical* feature as the prime consideration in this form of time-limited institutional care. As matters stand now and promise more, the emphasis is on *care* as a part of a growing pattern of federally-supported involvement in more of the lives of more of its elderly citizens. The flow of patients from hospitals to post-hospital care areas can be justified by obvious medical needs. The concepts of necessity, obligation, and rightful due are liable to be interpreted differently by different disciplines.

Specific involvement by physicians in utilization review is not requested as a free service. The Act states that

"Costs incurred in connection with the implementation of the utilization review plan are includable in reasonable cases and are reimbursable to the extent

that such costs relate to health insurance program beneficiaries."

One opinion on payment was that physicians who serve on utilization review committees ("The operation of the utilization review plan is a responsibility of the medical profession") should be paid at the rate of \$25.00 an hour.

Aside from the present resort to nursing homes to get the program of extended care under way, there is an interesting awareness of the value of creating such facilities in or near hospitals under the control of the staff. This has promise.

It is more than likely that Extended Care Facilities in hospitals will differ from those in nursing homes. There will be more accessibility to medical regulation, a more careful review of the formalities by which patients are accepted, treated, and cared for, as well as all of the other assets of traditional hospital service. The hope for the Extended (medical) Care Facility of the future is that hospitals can receive the funds necessary to measure up to the need. This would help to solve some hospital problems as well as to put a stamp of effective medical care on these patients in transit. It is the step beyond acute care in the hospital service areas that needs to be kept clear for the functions best served by the high competencies of a hospital. This role can be impaired if the movement of patients to the next reasonable form of care is impeded.

Diagram I

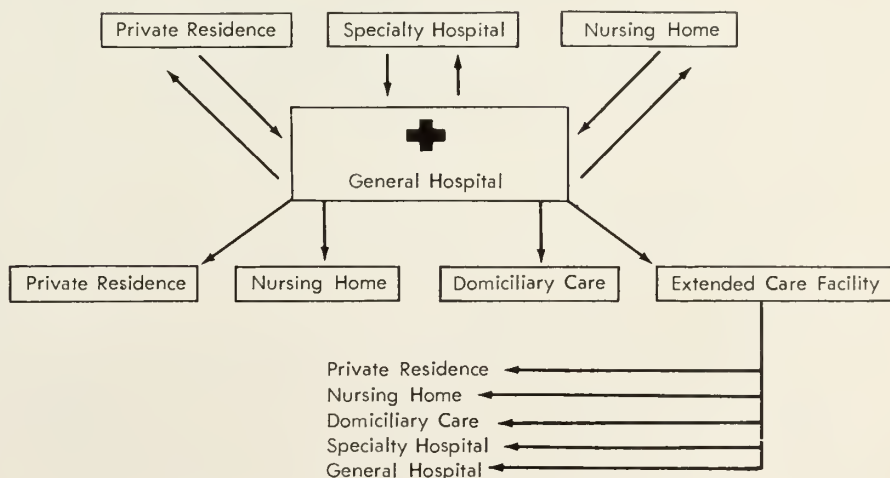


Table 1

	Rules and Regulations for Infirmaries Units Nursing Homes of Non-Profit Homes (An Administrative Code)	Office of Aging Pennsylvania Department Public Welfare	Regulations: Federal Health Insurance for the Aged	Conditions of Participant Extended Care Facilities
General Description:	"An infirmery shall be constructed, organized, equipped, staffed, and managed to provide adequate supervision, medical and nursing care to all patients admitted therein." "An infirmery shall have an administrator who shall be responsible for directing the activities of the infirmery . . .		"An extended care facility means an institution or distinct part of an institution with a hospital transfer agreement, that provides inpatient medical, nursing, diagnostic, diet, and rehabilitation care. Such units must have policies devised with the advice of professional personnel, including physicians and nurses, have both on its medical staff, and must be under a physician's supervision." It is "an intermediate institution which provides post-hospital, subacute services . . . to continue care."	
Personnel: Charge Nurse	"An infirmery with nineteen (19) patients or fewer shall have either a registered nurse or a licensed practical nurse in charge of nursing service. An infirmery with twenty (20) patients and above shall have a registered nurse in charge of nursing service."		"The health care of every patient must be under the supervision of a physician."	
Other Re- quired Nurs- ing Personnel	Day duty —1:8 or major fraction thereof Evening duty—1:12 or major fraction thereof Night duty —1:20 or major fraction thereof		Such units must have "a physician, a registered professional nurse or a medical staff responsible for the execution of such policies."	
Admission Policy:	"An infirmery shall admit only those patients whose nursing care and physical needs can be provided by the staff and infirmery."		"The extended care benefits provided by the health insurance program for the aged is intended to be a benefit for those persons who, though they no longer require the level of intensive care ordinarily furnished in a general hospital, continue to need for medical reasons a level of care entailing medically supervised skilled nursing and related services on a continuing basis in an institutional setting. The extended care benefit covers not only postacute hospitalization when the individual is convalescing or being rehabilitated but also those types of cases where the patient may continue to be severely ill and indeed have little or no prospect of recovery."	
Drugs:	"on the written order of a physician."		"All medications administered to patients are ordered in writing by the patient's physician."	
Medical Services:	"Each patient shall be under the medical supervision of a physician licensed to practice in the Commonwealth of Pennsylvania." Physical examination is required within 48 hours admission or one done by a physician within 30 days of that admission. There shall be an annual physical examination including urinalysis, CBC, and chest x-ray. The patient must be visited in 48 hours by a physician. The infirmery must offer rehabilitation services.		"Patients in need of skilled nursing care are admitted only upon the recommendation of a physician; their health care continues under the supervision of a physician; and the facility has a physician available to furnish necessary medical care in case of an emergency." "The medical evaluation of the patient is based on the physical examination done within 48 hours of the patient's admission unless such an examination was performed within 5 days prior to admission." "Patients are seen by a physician at least once every 30 days." "Restorative services are provided upon written order of the physician." "All diagnostic services are provided only on the request of a physician."	
Records:	A complete medical record is required.		"A clinical record is maintained for each patient admitted in accordance with accepted professional principles."	

A post-hospital arrangement of the type provided under law, and significantly medical at all levels, must be understood fully by physicians and patients. In the United States there are roughly 30 million hospital admissions annually. It is estimated that six million of these patients are sixty-five years of age and over. The hospital tenure of this older group is twice that of those of lesser age, and there is a much greater likelihood of the need for additional care subsequent to the hospital for this older age group before the possibility of returning home can be effected.

As a test of the logical places where information about the plan for Extended Care Facilities and implementation of this provision should be known, county medical societies in the Commonwealth of Pennsylvania were asked two general screening questions. The purpose of these questions was to determine to what extent organized medical groups such as county medical societies knew of Extended Care Facilities eighteen months after the law had been passed, and what is being done on the basis of this information. The second question was asked to determine to what degree state agencies responsible for initiating accreditation of such facilities have been in touch with county medical societies that are charged directly and indirectly with the administration of such units.

The first question was:

1. In what way has your county medical society participated in the implementation of the functions of the Extended Care Facilities in your county?

The affirmative responses fell into two categories, namely, direct involvement of the county society, and indirect involvement through members of the society but not on an official basis.

In six counties, the society has been active in every phase of extended care and its utilization.

In twelve counties, members of the society have been active on planning committees or advisory boards, primarily through their hospital affiliations, as they apply to Extended Care Facilities.

In twenty-nine counties, there were no formal actions on the part of the county medical society. This group included the largest metropolitan area in the Commonwealth and covered

probably more than half of the state's entire population.

2. To what degree has your county medical society been approached by the appropriate state agencies in Harrisburg with regard to mutual responsibilities to such facilities?

One county society received letters and other general mailing material.



■ Dr. Freeman is chairman of the Commission on Chronic Illness and Geriatrics and member of the Council on Scientific Advancement of the Pennsylvania Medical Society.

The second county medical society initiated the creation of a tie between it as a society and the state agency. In forty-five out of the forty-seven counties responding, there was no major communication between the state agency delegated to submit units for accreditation after physical review and the organized medical body of the area in which at least a major measure of responsibility for the unit had been written into the law.

3. A third question was posed in an indefinite fashion in order to attract general opinion. It asked what the county society was planning to do about approaching the problems of Extended Care Facilities voluntarily and what actions should it take to involve itself with a responsible state agency.

In twenty-nine counties, the reply was negative on both scores.

There was a variety of answers in the remaining eighteen. In nine counties long-range plan committees

or similar study groups had been established to review the relationship between hospitals and Extended Care Facilities. In another six offers of cooperation were made if they were kept informed and were given leadership. Two supported general educational programs. Only one county was completely organized and functioning in the full range of this law.

In conclusion, the Extended Care Facility must develop as an important part of the continuity of health services. Designated as the responsibility of the physician who is protected by a number of regulations, the advantages to patient and doctor will be lost if there is a failure to identify values and lines of authority. Nursing homes must expand their scope to become such a facility. In such action, they can strengthen their bonds to hospitals and to physicians. Those skilled nursing homes and other institutions that choose to pass up this opportunity will help to bring definition into the nursing home field that has been forced in many ways *de facto* to serve as hospitals.

The expansion of hospital-directed efforts into extended care can set standards and guarantee values for other institutions that elect to accept a program of an Extended Care Facility. This is an opportunity for the physician to enforce his place in the spectrum of health services, to do it on his own terms, to use his own traditional objectives, and to use the protection of a federal act in these functions. A failure to understand the full implications of extended care will be an impairment to the concept of health programs that must be best fitted to those able to direct them.

About that
excuse for not
wearing your
safety belts:
It isn't
good enough.

Help the Needy!



A patient of advancing years may appear to “have everything,” but may well be in need—*medically*. You know the symptoms. She’s tired most of the time. Though there’s nothing wrong with her organically, she suffers from general malaise. Lassitude has become her way of life . . . vague aches and pains her major concern.

Such a patient has entered the “Mediatric Age”—that stage of her life in which she’s an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support she’s apt to need. MEDIATRIC is intended to help keep her more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition

to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal

bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—
		(Contains 15% alcohol†) †Some Loss Unavoidable

Mediatric® tablets • capsules • liquid

Steroid-nutritional compound



AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada

6837



AMA

22ND CLINICAL CONVENTION

MIAMI

BEACH

DECEMBER 1-4, 1968 • CONVENTION HALL

... the American "Riviera." Where glittering luxury hotels tower above glamorous Collins Avenue; and medicine, sea and sunshine mix in a delightful subtropical setting.

Register now, and be on hand for the world's largest winter medical meeting—the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.



Choice of location—for the wife or business?

The Physician's Business

by
HORACE M. COTTON

I thought that I might throw out a few principles of what constitutes a fair and adequate reward for practicing medicine competently and to the satisfaction of patients. I don't necessarily mean a maximum reward—let's call it the optimum reward—which many physicians whom I meet do not get. I am going to take four broad categories, factors, call them what you will—labels on packages, if you like—four factors which need to be in balance if a doctor is to reap the optimum net reward for practicing good medicine.

There is actually a fifth factor. The fifth factor is: you. To be candid, no management consultant can really do much about you. There is no magic wand which anyone can wave over a doctor to make him a better doctor.

If you have the professional ability, then, of course, a business consultant can show you how to put it to best business advantage. But if you don't have the best professional ability, let's be straight about it, there is nothing that a management man can do to improve you as a doctor.

The first label on the first package is volume.

By volume I mean the number of patients you have, the size of your practice. Many good doctors don't have as many patients as they should have. Many doctors who are not so good have a great many more patients than they really have a right to expect. There are reasons for this—business reasons.

One reason is a doctor's choice of location. Now there may be some

physicians here who have recently gone into practice in a particular locality. Sometimes they go into that locality because they like it or because their wives like it or because it has some particular attraction for themselves or for their families which strictly has nothing at all to do with medicine.

A great many doctors go wrong on choosing a locality because they fail to go where they are needed.

In some areas, the United States is greatly over-doctored. For example, in San Francisco there is one doctor for every three hundred people. On the island of Manhattan, 13 miles long and two and a half miles wide, there are 7,000 M.D.'s. But there are vast stretches of this country which are under-doctored and calling out for doctors.

In the state where I live, North Carolina, comprised of a hundred counties, almost 30 of them are entirely "general practitioner" counties. Specialties have still to come to large areas of the South. So there is also a great need for specialists in many, many areas of this country. The specialist who chooses one of those areas is virtually assured from the beginning of optimum net income.

The man who chooses an over-doctored area and attempts to buck stiff competition, is likely to spend a good many years and have a good many heartaches building up a satisfying and rewarding practice.

Well, suppose a doctor has arrived in an area where there is room for him; where the volume, the potential is there. There are some practical things for him to think of when he arrives there. I will just begin with what we call his facility; in short, his office.

I don't think I have been in any of your offices, but I would not mind betting that some of them are less than satisfactory. I am sure someone here has an office that is too small, that is poorly laid out, that is, perhaps, even noisy.

A good facility is really an essential factor. In your profession, for example, I find that very commonly doctors do not provide enough space for the reception of patients. We have yardsticks for these things. For example, we say that a doctor may calculate the size of his reception room in this manner:

First, determine the number of patients you see in one hour on a busy day—I don't mean a light day . . .



Planned program of equipment replacement

I mean a peak day. Let us suppose, on a busy afternoon you are seeing old patients. Let us say that you see five an hour, four plus a work-in. Then we say you need 15 seats—three times five. Five for the patients, five for the people who come with the patients, and five to allow for a pile up because you are late arriving at the office and everybody is waiting for you.

Fifteen patients, you will be interested to know, fifteen seats require 300 square feet. Three hundred square feet is 20 square feet per patient and that is about the right size for people to sit in.

So if you have a reasonably busy office, whether you are solo, or in partnership, or in a group, you calculate five patients per doctor per hour. Then figure out three times that number of seats at 20 square feet per patient. And some of you may easily find that you come up short.

Then, there is the question of a consultation room. A great many physicians have quite tiny consultation rooms. To accommodate a normal sized desk and two chairs—one for the doctor and one for the patient, and that is not enough, there should be two chairs, one for the patient and one for the patient's friend or relative—and a bookcase. These furnishings require 120 square feet in order to be able to walk all around the desk. That is 10 by 12 feet.

So, ten by twelve feet is optimum for a consultation room. For an examining room, in order to walk all around your examining table, eight by ten, 80 square feet.

If you have an x-ray facility, 14 by 10. And so on. All these sizes are easily charted and it really is quite simple if you get hold of these figures to find out how much space you really should have for your efficiency and your patient's comfort.

The number of examining rooms you require will depend largely upon the volume of your practice. But certainly two is not sufficient, even if you are solo. Three is actually the minimum number.

I have a friend, a doctor, who sums is up very well. He says the secret of efficient work in a medical office is to have a lot of doors, to open them frequently and close them promptly, behind you.

By and large, since I am talking about yardsticks, figure on a thousand square feet per doctor; and do a little bit of mental calculating and see how much you fall short of that yardstick.

Your office should be well and adequately equipped. I meet so many doctors who have good equipment that is obsolete.

We know that automobile manufacturers follow a policy of planned obsolescence. They re-design cars every year in order to make you dissatisfied with last year's model and have a new one with the latest fins or whatever gimmick or design is popular this year. Now this is not true of medical equipment. When medical and surgical professional equipment is changed, when a model is changed, it is usually because of a real improvement.

I shudder sometimes when I meet

doctors who are very proud of the fact that all their equipment in the office has been fully depreciated and is now costing them nothing—they think. Of course, it is actually costing them a lot.

I would say to you that if you do have equipment in your office that is fully depreciated, it is time to change; it is out of date. It may be perfectly effective and you may say, "But, Mr. Cotton, there are years of life left in this." I know there are years of life left in it. There are years of life left in me but I am growing old. And young men just do better work.

So I would suggest that you have a planned program of equipment replacement and, at the very least, you should replace annually any equipment on which you no longer have a depreciation allowance. Remember Uncle Sam will help you considerably in the purchase of new equipment, particularly these days. You get a first year depreciation allowance of 20 per cent of the cost of the equipment; you get an annual depreciation allowance of at least 10 percent a year of the the remaining cost. You get an investment credit now which has just been restored. Uncle Sam's contribution to the cost of new equipment is really in these days quite munificent.

There is very little excuse for having Army-type World War II examining tables and similar equipment in your office.

These things are important to patients. What I say about professional equipment applies to your furnishings in your public areas, reception areas, and so on. If your office has anything in it which came from the rumpus room back home, take it back.

American people are typical of people everywhere. Given a choice between two doctors, since they have really no means of distinguishing between them, they are apt to be influenced by outside factors. The office is one of these factors.

Given a choice between two doctors, one with an extremely attractive, spacious, comfortable office, and one with an unattractive office, they will choose the one with the good office. But, unfortunately, if they are given a choice between a good doctor with a bad office and a poor doctor with a beautiful office, they will often choose the beautiful office. They have no other criteria to determine your professional ability and they are influenced by these outside factors.

Get the best office you can afford, furnish it as well as you can afford, and it will pay off. This is in a way a digression, but since there may be a question about it later, I will mention it now. Every reason you have for owning your home goes double for owning your office because your home is a source of expense and your office is a source of revenue. I know of no better investment than an excellent doctor-owned office.

There are many ways of owning an office. There is the corporate form, and all kinds of ways which have tax advantages and other advantages. But office ownership is an excellent thing for doctors.

Part of the office is the personnel. I see some ladies here. I assume that some of them are doctor's wives. I suppose it is possible that some of these assist doctors in their offices. I am going to talk about ladies who help doctors in their offices.

I know how hard it is these days to hire a girl who is even semi-literate. It is exceedingly difficult. But I can tell you something, gentlemen: You will never hire them unless you pay them and this is what a great many doctors don't do. At least they don't pay them adequately. You have to compete these days. You have to compete with industry, you have to compete with other professional offices—legal secretaries and this kind of thing.

The insurance companies pay relatively fabulous amounts for good stenographic and clerical help. The government offers extremely attractive salaries to its lower grades and very poor ones to its higher grades. So you are in a highly competitive field.

Now good girls are not unemployed. You don't get them through employment agencies. The good medical assistants already have jobs. So the only way to get them is to pay them, that is all. Just go out and pay the correct wage.

I have a client in New Orleans, he is a neurosurgeon, and he pays his secretary for secretarial work only, a thousand dollars a month. She is well worth it. The way he got her is interesting.

He was beefing about a succession of bad secretaries and he said to me one day: "I just wish I had"—and I will invent this name, he said—"I just wish I had Joe Hopkins' secretary." I said: "Well, why don't you get her?" He said: "How?" I said "Call her up."

So he called her up and that is how

he got her, and she is worth a great deal more than that.

Now don't get me wrong. I am not really suggesting that you go pay your secretaries a thousand dollars a month. But I am suggesting that you don't pay them \$50 a week either.

You hear sometimes about fringe benefits for doctor's assistants. I speak from a long experience. The prestige of working for a doctor is great but they don't take it at the A & P store in exchange for groceries. The fringe benefits that are given by industry are extremely attractive to many people but they are not particularly attractive to young women who are in relatively short-term employment, who intend to work for you only three, five or six years and then leave to become housewives, mothers, and so on. Benefits many years ahead are less attractive to them than immediate benefits in the form of a paycheck.

The first and most important thing about good personnel, about getting good personnel, is to pay them adequately—which many doctors do not do.

Sometimes you have to overcome the impression made on your patients by your employees because they very often see the patient before you do. The impression made upon a patient by the first person he sees in the doctor's office, whether or not it is the doctor, is tremendously important.

I go into a great many offices. I have been in probably 2,000. It makes

a great difference to be greeted, it makes a great difference to be taken notice of. That is what people want. After all, when a new patient comes to you he is either sick or he thinks he is. In any event, what he needs right from the start is reassurance. That is the first stage in the treatment.

If, instead of being reassured, he is agitated and upset by his greeting, or lack of greeting and so on, then when it comes your turn to see the patient you have this initial poor impression to overcome.

If you have a secretary or a nurse who is too old, too fat, too sour, domineering, possessive, dictatorial, who pushes the patients around and who generally behaves as if it were her practice and not yours, fire her tomorrow.

You may say to yourself. Well, I have someone like that and I would love to fire her but I can't, she is invaluable, she is indispensable, she knows everything, she does everything, I don't have to lift a finger, she protects me, she is just wonderful—but I hate her. In that case, don't wait until tomorrow, call her on the phone and fire her, because you can't afford that kind of an employee.

And as for her indispensability, show me your local graveyard and I will show you a great number of people who were indispensable for many years and are no longer in that position.

Figure the patient-to-seat ratio



Don't minimize ever the importance of tip top help in your office. If you are fortunate enough to get it, consider it a good investment to pay well for it.

You are a good doctor. You have an excellent facility, loads of space, lots of comfort, and an absolute crack-crjack personnel, and everybody is made welcome and people are lining up on the sidewalk in order to be able to see you, so you don't have a volume problem. Your next problem is a very short word: Fees. The four letter word that doctors hate most.

I have a great many clients who wish they never had to charge patients,

were small, before the National Health Service came into being, they were too young to know anything about the bills their fathers paid in those days. When they grew up and married, there was no such thing as fees for doctors, dentists, hospitals and pharmacists.

Therefore, they genuinely do not know what it is to pay these things. I have had to explain to one of my daughters a system where you do pay for them. She could not understand a system where you pay, because she had never been out of the country and just did not grasp it. In

extremely acute in these days.

I speak with some authority because I go there every year and have a tremendous number of doctors and lay friends who express considerable dissatisfaction with the British National Health Service.

But let me not get too far away from the economics of our type of medicine. I don't believe there should be one price for the same service by every doctor. I believe as a private entrepreneur the best product demands the best price.

In every community, there is a man, or men, who are acknowledged to



What he needs right from the start is re-assurance.

who wish they never had to have anything whatever to do with setting a price on their services. Well, I am sorry, ladies and gentlemen, but there is no way of getting out of it. As long as we live and practice under a private enterprise system of medicine, it will be necessary to set a price on your services.

I come from a country where there is no price on medical service, Great Britain. I have two married daughters in England. Neither of them knows what it is to pay a doctor, a dentist, a hospital, or a pharmacist. When they

fact, she said: "It sounds to me, Dad, rather like paying a policeman to catch a burglar. I just don't understand that."

I don't think we shall ever have, in this country a system based on the British National Health Service. I will go further to say I think in a very few years the British National Health Service is going to be drastically modified, not because of the dissatisfaction of the doctors, because the British government has coped with that for 19 years almost, but dissatisfaction of the patients is becoming

be superior to the others, perhaps by experience, age, natural brilliance, breadth of training . . . all kinds of reasons. There is a Paul Dudley White, shall we say, in every community.

While I don't see anything wrong at all in the man with the best product commanding the best price, the only thing that I think we have to be cautious of is in our personal assessment as the best man; because, of course, if we are all best, then we are also all worst. If everybody is top, then everybody is also the bottom, and

there is no such thing as a best man.

It requires a considerable amount of self-control and realism to appraise yourself as the top man in your community. If you can honestly and fairly do so, then I, for one, if you were my client, would say: Well, don't necessarily be bound by the going rates."

There is a great deal to be said for going rates where fees are concerned. I will define going rate for you. The going rate for a given service is the fee which a majority of physicians in your community do not exceed. It may not be the one which most of them charge, it is the one which, gen-

But since the days of relative value schedules and since so many third parties, for example, our Blue Shield friends, commercial insurance companies, government plans, and Medicare, have produced a wealth of knowledge, a wealth of statistics about medical charges generally have evolved nationally, regionally, and locally. There is a great deal more knowledge these days of going rates than there used to be.

So I would say this: For every physician there is a cheerful fee. By cheerful fee I mean the fee which your patients in your community will

now at the third package and its label, and that is the word "Collection." Because if you do have patients lined up on the sidewalk waiting to get in, and if you have fees which people are even anxious to pay or say they are, and you cannot collect them, then you will not get your optimum net income.

Business advisers think that OB-GYN is the specialty which can command the best collections. We expect OB-GYN men to collect 98 percent of their charges. We think that because we know that if the office is properly run and the collection system is properly organized, the patients



Cash on the barrel head for small charges.

erally, they don't exceed. It is a very useful guideline.

In recent years it has been much easier to discover going rates than it used to be. Some years ago if you asked physicians about fees it was really like asking fishermen about their catches: you never got the truth. Those who charged too much were ashamed to tell you; those who charged too little were ashamed to tell you. Both types took a guess at what somebody else charged that was related to neither of them. That used to be the going rate.

cheerfully pay you. They might not pay me, they might not pay him, but they will pay you. It requires a little research, perhaps a little art. But for every doctor there is a cheerful fee. And for most doctors, believe me, it is the going rate.

But if you have a reason, a good reason for not observing the going rate, then as far as I am concerned, as a business adviser, go to it. If you are worth it, ask it. If you are right, it will be cheerfully paid.

Now suppose you have lots of volume and cheerfulness. Let's look

can pay as they grow, and this is very satisfactory.

We think that pediatricians, and this surprises pediatricians, we think that pediatricians should be the next in order of collection success. They ask us why, and we explain to them that they have a large volume of small charges payable by grateful people, and this is true. No one is more grateful than a patient for the successful care of a child, provided that the collection is made when the gratitude is present and not when it has cooled off.

We think that internists should col-

*If you get volume right, fees right,
and collections right - -
then you have
just one problem left - -
how to pay your taxes.*



More of an investment for convenience

lect 95 percent of their charges, and this, of course, astonishes many internists who don't collect 95 percent.

We think that when you get into the realm of the specialties that have higher fees—surgeons, particularly the surgeons with quite substantial fees, neurosurgeons, orthopedists, and so on—the percentage of collection success drops; and we think somewhere between 90 and 93 is probably all right for these.

You will be interested to know that the low man on the totem pole is the general practitioner, and the lowest of all is the country general practitioner; and the country GP who collects 90 percent is doing awfully well.

I am going to inform you in two sentences the secret of good collections. The first sentence is this: Cash on the barrelhead for small charges.

Now by small charges I mean charges of \$10 or less. By cash on the barrelhead I don't mean that you station somebody with a hand out. It is simply this, give the patient the opportunity to pay at every attendance at the office. The simplest way of doing that is a little mechanical thing, a charge slip.

If you don't have charge slips, please try them. Use of charge slips encourages cash collections to what you will think an unbelievable extent. If you don't have charge slips, put them in and I will guarantee you an increase in your collections.

If somebody wants to charge, let them charge, but give them the opportunity to pay and you will be surprised at the way patients take advantage of this opportunity.

All right, that is the first sentence: Cash on the barrelhead for small charges. Now the other half of the secret: For charge accounts, regular, punctual, polite monthly statements for the money. Just keep asking. Keep asking either until you get it or until you are willing to abandon it. But don't, for goodness sake, as so many doctors do, keep dead file or delinquent file or whatever you like to call it that you are never going to do anything about it at all and yet you kid yourself that these are accounts receivable. They are not. They are accounts surrendered and you might just as well recognize it and get rid of them and cross them off.

I do think that you belong to a humanitarian profession. However, at any time you may elect to provide a patient for medical service. I very

strongly object to patients nominating themselves as being the recipients of your charity. So I think that for people who can pay, you should pursue a definite, organized collection procedure.

I think it should end up, if necessary, with the referral of obstinate delinquents to an outside collection agency. Many doctors are proud of the fact that they have never sent an account to an outside collector. I would suggest to them that in that attitude they are wrong; they are just making trouble for other doctors. When a patient beats out one doctor, when a dead beat beats out one doctor, he goes around and beats out another; and he has a trail of them all the way around town.

I think it is salutary and a benefit to your colleagues that for chronic, obstinate delinquents you turn them over for outside action. The fact that you may reap some return is really immaterial. That is not the part that concerns me. What concerns me is that you should not allow someone to sit you out just because you don't have the guts—and that is all it is—to ask for what is due you for what you have in fact done.

Well, you have the patients down on the sidewalk, you have cheerful fees, you have a good collection system, and now we come to package number four: That is overhead. How much does it cost you to run this practice that produces your gross income? The difference between your gross and your net is your expenses, your overhead.

Now overhead varies a great deal percentage-wise in the different specialties. The lowest overhead generally is the anesthesiologist's. The anesthesiologist usually doesn't have an office. He may have an office for merely clerical purposes, but his workshop is entirely the hospital and his tools are provided by the hospital and so on. So we expect him to have a low overhead. A psychiatrist does not have a very high overhead. After all, his equipment mainly consists of a couch.

The highest overhead is the radiologist's. His overhead is in the area of 55 to 60 percent of the gross, which primarily is attributable to the high depreciation cost of the very expensive equipment he uses and the high cost of the materials he uses.

Physicians who have an x-ray can figure 40 percent as an acceptable overhead. If you don't have an x-ray 35 to 37 percent is acceptable.

We expect your overhead to be percentage-wise higher if you have x-ray equipment. X-ray is a very fine convenience to you, a great help to your patients, saves them a lot of journeys, and so on, but never kid yourself that x-ray is particularly a good financial investment. It is not. It is more of an investment for convenience than for financial gain. But let us say overhead is between 35 and 40 percent.

Now suppose your overhead is worrying you. What can you do about it? In the first place, look at your

HORACE COTTON is a native of Manchester, England, whose career in Great Britain included service in many health fields and culminated in his being chosen to head an Oxford bureau setup to design methods of keeping statistics of hospitalized sickness.

Since his arrival in the United States in 1950, he served as Executive Editor of *Medical Economics* and, in 1953, founded *Mastrom, Incorporated*, business advisors to more than 1,000 doctors in the medical and dental professions in eastern and southern states.

Mr. Cotton is an editorial consultant to *Hospital Physician*, a member of the *Society of Professional Business Consultants* and a former member of the *Certifying Board of Examiners of the American Association of Medical Assistants*.

This article adapted from an address to the Fifth Annual Meeting of the Pennsylvania Society of Internal Medicine.

payroll. We figure that you can afford about 8 percent of your gross on rent. By rent I mean rent and utilities—you know, electricity and all that sort of thing. If your rent is more than 8 percent of your gross, we worry and wonder whether you are paying too much for your space or you have too much space.

If your rent is less than 8 percent of your gross, we wonder and worry if you are a little pinched and have too little or it is too cheap or poor quality space.

Now for payroll, we figure 15 percent of gross is acceptable. If it is a little more, if it is 17 percent or so,

don't get excited. But if it is 20 percent, you have edema of the payroll.

There is kind of a Parkinson's Law about medical offices. All work expands to occupy all the time of all the girls the doctor can be induced to hire. There is always some work to be done, however many pairs of hands there are available to do it.

If you take 8 percent for rent and 15 percent for payroll, that is 23 percent of your gross. If you allow 12 percent of your gross for other things such as supplies, drugs, medical supplies, business supplies, telephone, answering service, taxes, insurance—all the myriad things that go up to make an overhead—12 percent for those things, you have your 35 percent.

Now the 12 percent usually is something you can't tinker with very effectively. If you are thinking of wielding the economy ax, don't start on that 12 percent, because all you will save probably will be paper clips, and they don't cost much. You won't get much of a percentage reduction on that.

You have to go where the money goes and that is the payroll. If you have a 20 percent payroll and you are worried about your overhead, then that is the first place to look.

A great many doctors make a mistake of penny ante economies and they overlook the big extravagance, which is too much help.

I will say in passing that many doctors whose gross is inadequate overlook the fact that they have too small a payroll. This can be bad, too. But mostly it is too large rather than too small.

I have one client who has no girl at all. He cleans his own examining room sinks in between patients, and that sort of thing—he really does. When he has a letter to dictate, he calls a number in Philadelphia and dictates the letter over the phone. When the next patient is due to be seen he pops his head out of his consulting room into his waiting room and says: "Next."

He says the telephone never has a headache and never stays off work and never needs a vacation and doesn't cost much money, so he likes to practice as a no-girl doctor. But I don't advise that.

Anyhow, if you get volume right, and fees right, and collections right, then you just have one problem left and that, of course, is how to pay your taxes. That is another problem which would take another paper to discuss.



Normal and Abnormal Circulatory Changes in Pregnancy

Part II

William G. Leaman, Jr., M.D. questions Solomon S. Mintz, M.D., Attending Cardiologist, Albert Einstein Medical Center, Philadelphia, Pennsylvania.

Is the presence of shock ever a problem later in pregnancy or at the time of delivery?

Shock may appear after delivery when mitral stenosis is present and there is difficulty in obtaining the required blood flow through a narrow mitral orifice.

What is your opinion regarding the use of quinidine or procaine amide for controlling annoying or persisting ectopic beats during pregnancy?

I do not believe that either of these drugs is contraindicated during pregnancy provided they are given in proper amounts and keeping with other cardiac factors noted in the individual patient.

What factors may increase cardiac demand as pregnancy advances?

As previously noted, the pregnancy itself may be a factor. In the later months activities may be poorly tolerated and should be carefully adjusted. Infections of any type should be avoided whenever possible. In the pregnant cardiac patient abnormal increases in body weight should be prevented. The presence of a moderate anemia, as well as an ectopic rhythm, may also increase cardiac demand. Relief of tension is important. Hyperthyroidism, as a complication, should not be overlooked. Finally, pain from any cause and early congestive failure may greatly increase cardiac demand.

How can we decrease cardiac demand during pregnancy in these patients?

Control of congestive failure at all times is a necessary measure, prefer-

ably before delivery. The proper use of digitalis, diuretics, as well as fluid and salt restriction, are important here. Sedation should be given as required, and the schedule of activities should be reviewed so that appropriate adjustments can be made.

Is cardiac surgery ever indicated during pregnancy?

If possible, it is preferable to avoid cardiac surgical procedures (generally the use of prosthetic valves) during pregnancy. Older patients, particularly those in classes 3 and 4, may prove an exception. However, in these cases the opinion of a cardiologist should be sought.

What mortality may we expect when heart disease complicates pregnancy?

Here much will depend on the cooperation between the internist and obstetrician. Then the mortality figure should not exceed five percent.

Will you comment on anesthesia in labor and indicate the anesthetic of choice for cardiac patients?

As a rule, the opinion of a well-trained anesthetist will be necessary. However, ether is well tolerated by most cardiac patients and is generally given with oxygen.

Are therapeutic abortions necessary in cardiac patients?

They are rarely necessary provided the patient is cooperative and receives proper medical management.

Are any special considerations needed for the cardiac patient who has reached term and avoided congestive failure?

In these instances, many obstetricians consider it proper to shorten the second stage of labor with the use of forceps to insure the least

amount of disturbance to the mother's cardiac condition.

Does an abnormal blood loss during the third stage of labor benefit an overloaded heart?

The opposite is true. The patient with a diseased heart tolerates hemorrhage much less than the one with a healthy heart. Consequently every effort should be made to avoid this complication.

Should patients who exhibit congestive failure in one pregnancy contemplate future pregnancies?

Not as a rule. This group many times shows a greater incidence of congestive failure in later pregnancies. This is particularly true when the patient is older. However, in young patients successful surgical correction of valvular deformities during the interval may permit additional pregnancies.

What about the care of the mother during the post-natal period?

Medical supervision of the mother should not cease when the pregnancy is successfully terminated. The load on a damaged heart is increased in great measure by the care of a baby. These added duties may, in themselves, precipitate cardiac failure, particularly if the patient's responsibilities are increased too rapidly and are not under medical supervision. Therefore, adequate help around the home must be provided to give the cardiac patient added rest periods.

William G. Leaman, Jr., M.D., Fellow, Council on Clinical Cardiology of the American Heart Association, edited this Brief for the Council on Scientific Advancement, in cooperation with the Pennsylvania Heart Association.



Let's be specific about Campbell's Soups... and reducing diets

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101



In childhood



Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma,

hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

diarrheas...

- careful supervision
 - electrolyte replacement
 - specific anti-infective therapy
- and...

LOMOTIL[®]

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride 2.5 mg.

(Warning: May be habit forming)

atropine sulfate 0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates¹ conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito² used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge³ in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull⁴ added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

Children: Total Daily Dosage

3-6 mo. . . .	1/2 tsp.* t.i.d. (3 mg.)	↓↓↓
6-12 mo. . . .	1/2 tsp. q.i.d. (4 mg.)	↓↓↓↓
1-2 yr. . . .	1/2 tsp. 5 times daily (5 mg.)	↓↓↓↓↓
2-5 yr. . . .	1 tsp. t.i.d. (6 mg.)	↓↓↓↓↓
5-8 yr. . . .	1 tsp. q.i.d. (8 mg.)	↓↓↓↓↓
8-12 yr. . . .	1 tsp. 5 times daily (10 mg.)	↓↓↓↓↓
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.	↓↓↓↓↓

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El clorhidrato de difenoxilato en las diarreas infantiles, *Sem. Med. (Buenos Aires)* 127:475-484 (Oct. 4) 1965.
2. Grinszpan, I. L.; Goldstein, A., and Divito, J.: El clorhidrato de difenoxilato en las diarreas infantiles, *Sem. Med. (Buenos Aires)* 125:758-763 (Aug. 27) 1964.
3. Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, *Med. J. Australia* 2:921-922 (Nov. 27) 1965.
4. Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, *Amer. J. Dis. Child.* 108:236-242 (Sept.) 1964.

SEARLE

Research in the Service of Medicine

on call...

Keflin[®]
Sodium
Cephalothin



Eli Lilly and Company
Indianapolis, Indiana 46206

800486

Is it depression?
She says "I'm always on edge..."

**...but her other symptoms:
depressed mood, insomnia,
anorexia, feelings of guilt
strongly suggest
an underlying depression.**

when the diagnosis is depression

ELAVIL[®]HCl

(AMITRIPTYLINE HCl|MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.



MERCK SHARP & DOHME

Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY





○ Indicates courses being conducted in Pennsylvania.

ALLERGY

○ **Current Status of Vascular Grafting;** by Jefferson Medical College and Penn State University; at Pottsville Hospital, Thursday, November 14, 1968; 11:30 a.m. to 2 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

CHEST DISEASES

○ **Courses in Bronchoesophagology;** by Temple University School of Medicine and Hospital; at Temple University Health Sciences Center, 3401 N. Broad St., Philadelphia, Monday, January 13-24, 1969, Monday, April 14-25, 1969. Fee for Course \$350. Contact Charles M. Norris, M.D., or Gabriel F. Tucker, Jr., M.D. at Chevalier Jackson Clinic, Temple University Hospital, 3401 N. Broad St., Philadelphia 19140.

DERMATOLOGY

○ **Management of Common Dermatitis;** by Hahnemann Medical College, at Community General Hospital, December 4, 1968. Contact Charles H. Wang, M.D., 145 N. 6th St., Reading, Pa. 19601.

○ **Office Management of Common Dermatologic Problems;** by Jefferson Medical College and Penn State University; at Williamsport Hospital, Wednesday, November 20, 1968; 11:00 a.m. to 2:30 p.m.; AAGP 3 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

ENDOCRINOLOGY

○ **Newer Concepts of Thyroid Disease;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, November 11, 1968; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Modern Treatment of Diabetes;** by Hahnemann Medical College, at Community General Hospital, Reading, January 8, 1969. Contact Charles N. Wang, M.D., 145 N. 6th St., Reading, Pa. 19601.

○ **Endocrinology;** by Jefferson Medical College; at Philadelphia, Tuesday, January 7-February 11, 1969; 12 course hours; AAGP credit applied for; fee \$50; minimum number required 30, maximum permitted 100. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

GENETICS

○ **Clinical Application of Genetics;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, December 16, 1968; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

GENERAL

○ **Emergencies in Medical Care;** by Hahnemann Medical College and Hospital; at Marriott Motor Hotel, Philadelphia Monday, December 8-12, 1969; fees \$150—Paramedics \$35; minimum number required 200, maximum permitted 600. Contact Stanley Spitzer, M.D. or Wilbur W. Oaks, M.D., Hahnemann Medical College and Hospital, 230 N. Broad St., Philadelphia 19102.

○ **Post-Operative Fluid Therapy;** by Jefferson Medical College and Penn State University; at Conemaugh Valley Memorial Hospital; Johnstown, Tuesday, November 26, 1968; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

GENERAL MEDICINE

○ **Diagnosis and Management of G. I. Hemorrhage;** by Hahnemann Medical College and Grand View Hospital, Sellersville; at Grand View Hospital Nurses Home, Sellersville, Wednesday, November 20, 1968. Contact D. Henry Ruth, M.D., Grand View Hospital, Sellersville, Pa. 18960.

○ **The Retinal Manifestations of Systemic Disease;** by Jefferson Medical College and York Hospital; at York, Thursday, November 21, 1968; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Symposia on Shock: Medical and Surgical;** by Jefferson Medical College and Penn State University; at Mercy Hospital, Scranton, Wednesday, November 20, 1968; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **The Echo as a Diagnostic Procedure;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, December 9, 1968; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **The Physician and His Role in the Prevention of Coronary Disease;** by Jefferson Medical College and York Hospital; at York, Thursday, December 12, 1968; fee \$50 for 112 hours, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Full day visit—with afternoon rounds. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Nuclear Medicine—Its Present Capabilities—Its Future Promise;** by Jefferson Medical College and York Hospital; at York, Thursday, December 5, 1968; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Antibiotics: An Updating;** by Jefferson Medical College and Penn State University; at Altoona Hospital, Thursday, December 19, 1968; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Absorption and Malabsorption;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, Chester, Monday, December 2, 1968; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Cleft Palates and Other Oral or Pharyngeal Abnormalities in Infants—Their Approach and Repair;** by Jefferson Medical College and York Hospital; at York, Thursday, December 19, 1968; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Symposia on Hepato-Biliary Problems;** by Jefferson Medical College and Penn State University at Mercy Hospital, Scranton, Wednesday, December 18, 1968; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Immunologically Induced Drug Reactions;** by Jefferson Medical College and Penn State University; at Allentown Hospital, Thursday, November 14, 1968; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **The Physician and Premarital Counseling;** by Jefferson Medical College and York Hospital; at York, Thursday, January 16, 1969; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **CPC and Pulmonary Function Studies in the Evaluation of Dyspnea;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, November 18, 1968; 2:00 to 5:00 p.m.;* AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Treatment of the Patient with an Isolated Pulmonary Lesion;** by Jefferson Medical College and Penn State University; at Pottsville Hospital, *Thursday, December 12, 1968; 11:30 a.m. to 2 p.m.;* AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Clinical Pathological Conference;** by Jefferson Medical College and Penn State University; at Conemaugh Valley Memorial Hospital, *Johnstown, Thursday, December 12, 1968; AAGP 2 hours;* no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Thyroidectomy;** by Jefferson Medical College and Penn State University; at Allentown Hospital, *Thursday, December 12, 1968; AAGP 3 hours;* no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Diseases of Medical Progress: Opportunistic Infections;** by Jefferson Medical College and Penn State University; at Allentown Hospital, *Thursday, January 9, 1969; AAGP 3 hours;* no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Digitalis Intoxication;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, January 6, 1969; 2:00 to 5:00 p.m.;* AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Impact of Hallucinogenic Drugs;** by Jefferson Medical College and Penn State University; at Pottsville Hospital, *Thursday, January 9, 1969; 11:30 a.m. to 2 p.m.;* AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

○ **Shock: Recognition and Management;** by Jefferson Medical College and Penn State University; at Altoona Hospital, *Thursday, November 21, 1968; 8:45 a.m. to 12:30 p.m.;* AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

OBSTETRICS & GYNECOLOGY

○ **Physician Counseling for Family Planning—How and Why?;** by Jefferson Medical College and York Hospital; at York, *Thursday, November 14, 1968; fee*

\$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Office Gynecology;** by Jefferson Medical College; at Philadelphia, *Tuesday, November 12-December 17, 1968; 12 course hours; AAGP credit applied for; fee \$50; minimum number required 30, maximum permitted 100.* Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

PHYSICAL MEDICINE AND REHABILITATION

○ **Current Concepts of Rehabilitation for the Practitioner;** by Albert Einstein Medical Center; at Philadelphia, *Wednesday, January 15-February 19, 1969; AAGP 18 hours; minimum number required 10, maximum permitted 20; fee undecided.* Contact Solomon Mintz, M.D., Albert Einstein Medical Center, York and Tabor Roads, Philadelphia 19141.

PSYCHIATRY

○ **Advanced Seminar in Adult Office Psychiatry—Course #2;** by Temple University Health Sciences Center, *Philadelphia, Wednesday, November 6, 1968 to January 22, 1969; AAGP 30 hours; fee \$30; maximum number permitted 10.* Contact Barney M. Dlin, M.D., Temple University Health Sciences Center, Broad and Tioga Sts., Philadelphia 19140.

○ **The Physician and Sex Education—Part II;** by Jefferson Medical College and York Hospital; at York, *Thursday, November 7, 1968; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours.* Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Psychodynamic Implications of the Physiological Studies in Sensory Deprivation;** by Department of Psychiatry and Neurology of Woman's Medical College of Pennsylvania; at Philadelphia, *Monday, November 11, 1968.* Contact Mrs. Anne Insinger, Woman's Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia 19129.

○ **Advanced Seminar in Adult Office Psychiatry—Course #2;** by Temple University Health Sciences Center, *Philadelphia, Wednesday, November 6, 1968 to January 6, 1969; AAGP 30 hours; fee \$30; maximum number permitted 10.* Contact Barney M. Dlin, M.D., Temple University Health Sciences Center, Broad & Tioga Sts., Philadelphia 19140.

○ **Psychedelic Drugs;** by Hahnemann Medical College and Hospital; at Marriott Motor Hotel, *Philadelphia, Friday, November 22-24, 1968; fee \$100; maximum permitted 400.* Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Psychiatry in Medical Practice—Basic;** by Hahnemann Medical College and Hospital of Philadelphia, *Thursday, December 5, 1968-February 20, 1969.* Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Psychiatry in Medical Practice—Advanced;** by Hahnemann Medical College and Hospital of Philadelphia, *Wednesday, December 4, 1968-February 19, 1969; Wednesday, February 26-April 30, 1969.* Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Case-oriented Seminars on Psychiatry in Medical Practice;** by Staunton Clinic, at Pittsburgh, *Wednesday, December 18 and 19; Thursday, January 2-8, 1969; fee \$100.* Contact Charlotte M. Florine, M.D., Staunton Clinic, 3601 Fifth Ave., Pittsburgh 15213.

SURGERY

○ **Anatomy and Surgery of the Hand;** by University of Pennsylvania, Div. of Graduate Medicine at University of Pennsylvania, Division of Graduate Medicine, *Philadelphia, January 20, 1969-January 31, 1969.* Fee \$150.00, minimum number required: 20. Contact Paul Nemir Jr., M.D., Director, University of Pennsylvania Division of Graduate Medicine, 237 Medical Lab. Building, Philadelphia, Pa. 19104.

UROLOGY

○ **M/M and Pyelonephritis;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday November 25, 1968; 2:00 to 5:00 p.m.;* AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Urologic Problems in Children;** by Jefferson Medical College and Penn State University; at Williamsport Hospital, *Wednesday, December 18, 1968; 11:00 a.m. to 2:30 p.m.;* AAGP 3 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Short Course on Renal Disease;** by Jefferson Medical College and Penn State University; at St. Luke's Hospital, *Bethlehem, Thursdays, January 16, February 20, March 20, April 3 and 17, May 15, 1969; 9:30 a.m. to 12 noon; fees: \$24 for six sessions; \$7 per single seminar; AAGP 3 hours per session.* Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

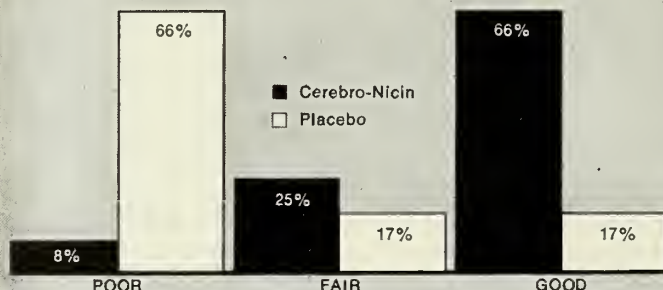
○ **Chronic Renal Failure;** by Hahnemann Medical College and Grand View Hospital, Sellersville; at Grand View Hospital Nurses Home, *Sellersville, Wednesday, January 22, 1969.* Contact D. Henry Ruth, M.D., Grand View Hospital, Sellersville, Pa. 18960.

For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin® capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jr., of the Amer. Ger. Soc., June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole.....	100 mg.
Nicotinic Acid.....	100 mg.
Ascorbic Acid.....	100 mg.
Thiamine HCl.....	25 mg.
1-Glutamic Acid.....	50 mg.
Niacinamide.....	5 mg.
Riboflavin.....	2 mg.
Pyridoxine.....	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.



Write for literature and samples...

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

in the treatment of IMPOTENCE



Android® (thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY

ANDROID

GOOD TO EXCELLENT 75%

PLACEBO

20%

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Android-HP

HIGH POTENCY

Android-X

EXTRA HIGH POTENCY

Android-Plus

WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each yellow tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . . 10 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1000.

Each red tablet contains:
Methyl Testosterone . . . 5.0 mg.
Thyroid Ext. (1/2 gr.) . . . 30 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1000.

Each orange tablet contains:
Methyl Testosterone . . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 or 2 tablets daily.

Available:

Bottles of 60, 500.

Each white tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/4 gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . . . 250 mg.
Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate . . . 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.

Dose: 2 tablet twice daily

Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057



also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, postoperative and debilitating disease, osteoporosis. DOSE: One tablet 1 i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRAINDICATIONS: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

SAFEGUARD AGAINST BREAST CANCER

MAMMOGRAPHY BREAST X-RAY EXAMINATION

Indications For Mammography

1. Presence of a questionable mass
2. Discharge or bleeding from nipple
3. The remaining breast after a mastectomy for malignant disease
(Should be repeated annually for 10 years)
4. To help persuade the resistant patient
5. In the apprehensive person with cancer in the family

Normal Breast Mass



Benign Mass



Malignant Mass



THE PRESENCE OF CALCIFICATION IS DIAGNOSTIC

Mammography Is Available In Many Accredited Hospitals and Radiologists Offices

Douglas B. Nagle, Jr., M.D.
Consultant

AMERICAN CANCER SOCIETY

PENNSYLVANIA DIVISION

PHILADELPHIA DIVISION

PENNSYLVANIA CANCER FORUM PAGE—presented cooperatively by the Council for Scientific Advancement of the Pennsylvania Medical Society, the Philadelphia and Pennsylvania Divisions of the American Cancer Society and the Cancer Control Section, Pennsylvania Department of Health.



meetings

NOVEMBER

Annual Meeting, Pennsylvania Division, American Cancer Society, November 6-7, 1968, Host Farm Motel, Lancaster.

PMS Pennsylvania Cancer Coordinating Committee, November 17, 1968, PMS Headquarters, Lemoyne.

PMS Council on Scientific Advancement, November 21, 1968, PMS Headquarters, Lemoyne.

American College of Physicians (Ohio, Western Pennsylvania, West Virginia Regional) November 22-23, 1968, University of Pittsburgh, Pittsburgh.

American College of Physicians (Eastern Pennsylvania Regional), November 15-17, 1968, Hershey.

Survival, Man and Water, November 9, 1968, College of Physicians of Philadelphia and Philadelphia County Medical Society.

PMS Committee on Objectives, November 14, 1968, PMS Headquarters, Lemoyne.

Pennsylvania Cancer Coordinating Committee, November 17, 1968, PMS Headquarters, Lemoyne.

American College of Physicians Regional Meeting, November 22-23, 1968, University of Pittsburgh, Pittsburgh.

62nd Annual Meeting, Southern Medical Association, November 18-21, 1968, New Orleans.

1968 Annual Conference, National Society for the Prevention of Blindness, November 20-22, 1968, Roosevelt Hotel, New York City.

41st Scientific Sessions, American Heart Association, November 21-24, 1968 and Annual Meeting, November 24-26, 1968, Bal Harbour, Florida.

American College of Physicians (Eastern Pennsylvania Region) Nov. 15-17, 1968, Hershey. Contact: George D. Ludwig, M.D., 3600 Spruce Street, Philadelphia.

International Symposium on Wine and Health, The University of Chicago Center for Continuing Education, Chicago, Saturday, November 9, 1968.

DECEMBER

American Medical Association, Annual Clinical Convention, December 1-4, 1968, Miami Beach.

American Medical Association, Tenth National Conference on the Medical Aspects of Sports, December 1-4, 1968, Miami Beach.

JANUARY

Board Meeting, PMS, Wednesday, January 8, 1969, Board Room, PMS Headquarters, Lemoyne.

ACHROMYCIN® V TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

**While waiting for the results of the sensitivity test,
start the therapy likely to succeed...**

Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

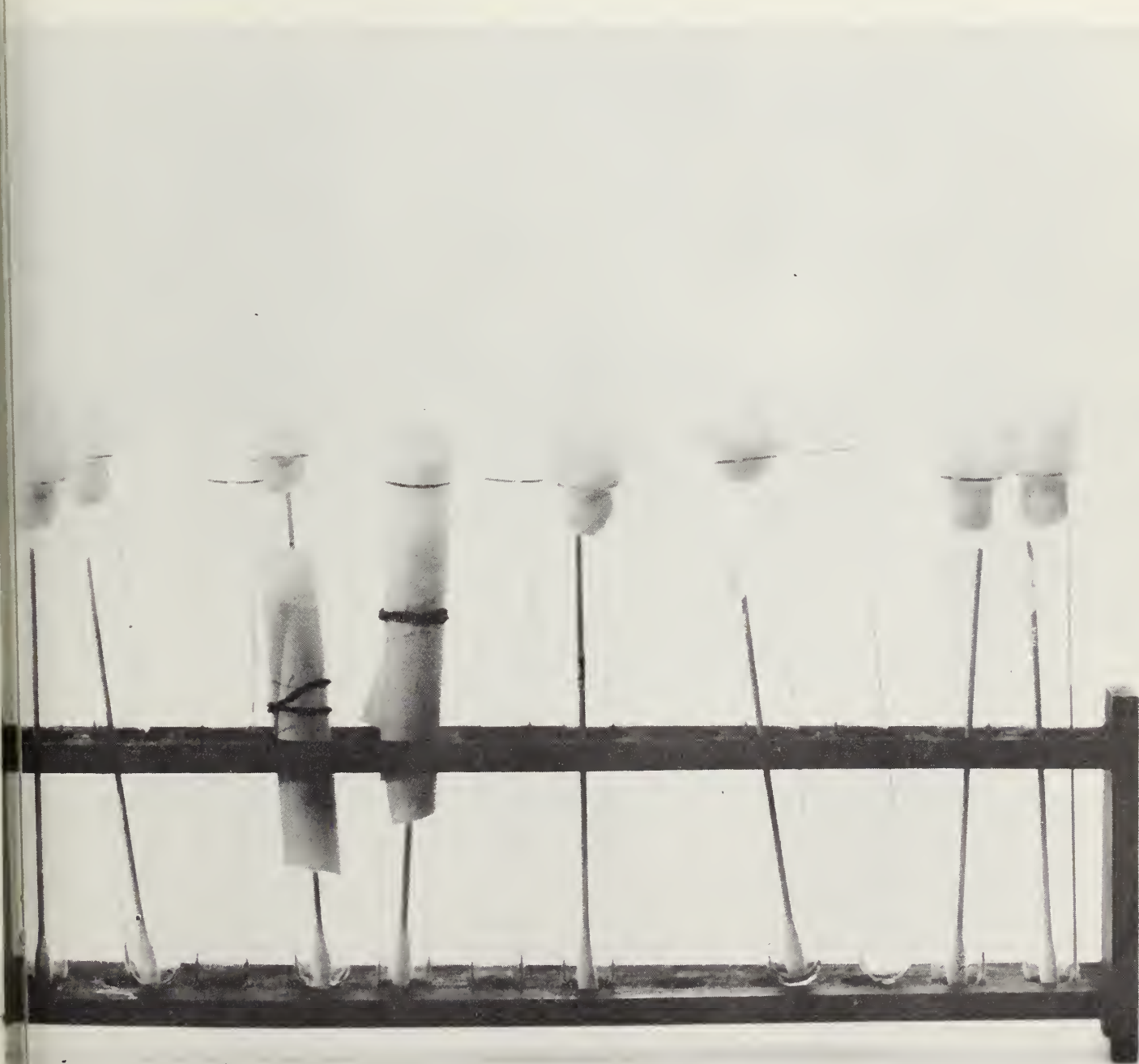
Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

ACHROMYCIN® V
TETRACYCLINE



*The price differential
is inconsequential.*

← Prescribing Information





○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Charles B. Daugherty**, Greensburg; University of Pittsburgh School of Medicine, 1918; age 74; died August 15, 1968. Dr. Daugherty was on the staffs of Westmoreland and Jeanette District Memorial hospitals. Surviving are his wife, a son, a daughter, seven grandchildren, two brothers, and a sister.

○ **Isadore Zugarman**, Philadelphia; Jefferson Medical College, 1931; age 60; died August 16, 1968. He was a Navy veteran of World War II. Surviving are his wife, a son, a daughter, a brother and a sister.

○ **James Jaeger**, Philadelphia; University of Pennsylvania School of Medicine, 1920; age 72; died August 15, 1968. He founded the department of neurological surgery at Jefferson Medical College Hospital, heading it until his retirement in 1961. He was president of the International College of Surgeons in 1944, the Medical Club of Philadelphia in 1960, and the Philadelphia Neurosurgical Society in 1961 and 1962. He belonged to the American College of Surgeons, Harvey Cushing Neurological Society and the Philadelphia Academy of Surgeons. He is survived by his wife, a son, a daughter, two brothers, a sister and five grandchildren.

○ **David A. Johnston**, Harrisburg; Jefferson Medical College, 1928; age 65; died August 16, 1968. He was a member of the American College of Surgeons and had served as surgeon for the State Police from 1938 until his retirement from the post three years ago. He was a surgeon with the Army in World War II. He is survived by his wife, three sons, a daughter, three sisters, and seven grandchildren.

○ **Harvey E. Jordan**, Philadelphia; University of Virginia School of Medicine, 1939; age 54; died August 24, 1968. He was a fellow of the American College of Ophthalmology and Otolaryngology, and assistant professor of medicine at the University of Pennsylvania Medical School.

He is survived by his wife, a son, a daughter, a sister and a grandchild.

○ **Howard A. Kerr**, Martinsburg; Hahnemann Medical College, 1933; age 59; died August 13, 1968. He is survived by his wife, two daughters, two grandchildren, four sisters, and two brothers.

○ **Oliver P. Kimball**, Lancaster; Western Reserve University School of Medicine, 1918; age 81; died May 7, 1968. We have received no information regarding survivors.

○ **David M. Melenson**, Philadelphia; Temple University School of Medicine, 1934; age 60; died August 17, 1968. He was a member of the American Physicians Committee, American Geriatric Society and the Israel Medical Association. He is survived by his wife, a son, two daughters, his mother, and a sister.

○ **Harry Lee Stollar**, Elizabeth; University of Pittsburgh School of Medicine, 1924; age 72; died August 18, 1968. He is survived by his wife, two daughters, two sons, a sister, and six grandchildren.

○ **Lewis D. Williams**, Meadville; University of Pennsylvania School of Medicine, 1934; age 59; died August 8, 1968. He was director of health services for the Pennsylvania Department of Public Health in Northumberland and adjacent counties and served as flight surgeon with the Navy in World War II and the Korean War. He is survived by his wife, two daughters, a son and, a brother.

○ **Louis V. Williams**, Littlestown; College of Physicians and Surgeons, Baltimore, 1911; age 83; died August 25, 1968. We have received no information regarding survivors.

○ **Herbert Fisher**, Philadelphia; Stritch School of Medicine of Loyola University, 1945; age 48; died September 2, 1968. He had served a term as president of the medical board of Episcopal Hospital in 1961 and was a fellow of the American College of Radiology. He is survived by his wife, three sons, a brother and a sister.

○ **Thomas R. Gagion**, Pittston; Georgetown University School of Medicine, 1912; age 77; died August

31, 1968. He had served as a trustee and counselor of the Pennsylvania Medical Society, and for two years as chairman of the board. He was a fellow of the Ophthalmological Society of Pennsylvania, and served in the Army Medical Corps during World War I. He is survived by his daughter, two brothers, one sister, and four grandchildren.

○ **Robert Megowan**, Philadelphia; Jefferson Medical College, 1932; age 63; died September 4, 1968. He was a fellow of the Industrial Medical Association. He is survived by his wife, a daughter, and three grandchildren.

○ **Michael Platt**, Philadelphia; Jefferson Medical College, 1917; age 72; died August 24, 1968. He served in the Army Medical Corps during World War I. He is survived by his wife, two sons, two brothers, three sisters, and six grandchildren.

○ **Irwin M. Pochapin**, Pittsburgh; University of Pittsburgh School of Medicine, 1916; age 72; died September 4, 1968. He is survived by his wife and two sons.

○ **Francis P. Shannon**, Philadelphia; Jefferson Medical College, 1911; age 81; died September 2, 1968. He served in the Army Medical Corps during World War I. He is survived by his wife.

○ **Carl Stamm**, Philadelphia; age 71; died August 31, 1968. He was an instructor of Otolaryngology at Temple Medical School and the Universities of Munich, Munster and Berlin. He came to the United States from Germany in 1937. He is survived by his wife, a daughter, a son, and six grandchildren.

Joseph L. Chick, DuBois; University of Pittsburgh Medical School, 1932; age 69; died Sept. 3, 1968. He is survived by his wife, a daughter, a son, six sisters and five grandchildren.

William W. Nelson, Harrisburg; Howard University Medical School, 1907; age 88; died September 3, 1968. We have received no information regarding survivors.

*Easy on
the Budget...*

*Easy on
the Mother*

*NN Tablets & Elixir NN
For Iron Deficiency Anemia*



BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS
Fergon[®]
brand of FERROUS GLUCONATE



Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

EASTERN PENNSYLVANIA OFFICE:

E. L. Edwards, D. R. Lawe, L. R. Wilson, Jr., and S. B. Elstan, Jr., Representatives
Suite 126-BC, The Benson, Jenkintown 19046 Telephone: 215-887-6335

WESTERN PENNSYLVANIA OFFICE: N. Wells and S. T. Ingram, Representatives
1074 Greentree Road, Pittsburgh 15220 Telephone: 412-531-4226



PHYSICIANS WANTED

Psychiatric Residencies—Norristown State Hospital. First, second and third year openings available in modern, dynamic training center with broad eclectic program which includes comprehensive community psychiatry, forensic, alcoholic, group and family treatment, geriatric, adolescent, adult, acute, day and night treatment centers. Medical school affiliations and others for psychophysiological psychiatry and intensive individual child adolescent and adult out-patient therapy, psychoanalytical oriented, thirty minutes from cultural Philadelphia; beautiful progressive suburban area, unlimited opportunities for practice. Housing and maintenance available. Salaries for licensed physicians begin \$10,954; unlicensed \$8,580. Call or write **DIRECTOR OF TRAINING AND EDUCATION**, Norristown State Hospital, Norristown, Pa. (215) 275-9700.

Needed—Staff physicians, internists and generalists: JCAH fully accredited ultra-modern 2000-bed chronic disease hospital (no psychotic or tuberculous patients); dynamic rehabilitation program; university affiliations; regular consultation available in all specialties; 5 day 35 hour work week; liberal paid vacations and holidays; pension plan; insurance and other fringe benefits; limited number of ranch type homes

and apartments available on the premises; Pennsylvania license required; salary competitive and negotiable. Contact **G. P. HAMMILL, M.D.**, John J. Kane Hospital, Pittsburgh, Pa. 15243.

Psychiatric residency training—2 year approved, third year in University connected Psychiatric Institute. \$8,580 to \$12,075; maintenance arrangements possible. ECFMG and/or license acceptable in Pennsylvania required. **R. L. GATSKI, M.D.**, Superintendent, Danville State Hospital, Danville, Pa. 17821.

Wanted: Two radiologists for progressive x-ray department in a 325-bed general hospital in western Pennsylvania. Equipment excellent, including 2 remote TV units. At least one applicant must be board certified. Many fine strictly residential areas within 10 minutes of hospital. Relations with administration excellent. All compensation negotiable. Personal interviews required. Need is immediate, but can await previous commitments. Send resume to Department 532, PENNSYLVANIA MEDICINE.

Anesthesiologist—Board eligible or certified. Developing department in expanding 185-bed specialty hospital of University Health Center group. Teaching and research opportunities.

Salary negotiable. Call or write: **J. R. QUINN, M.D.**, Eye and Ear Hospital, Pittsburgh, Pa. 15213.

Internist: Prefer individual who can work 40 hr. five day week. Pennsylvania license required. Salary to \$27,000.00 per annum depending upon qualifications. Contact: **THE MEDICAL DIRECTOR**, All Saints' Hospital, Philadelphia, Pa. 19118.

Physicians—Part or full time. Student and employee health service. Medical School hospital affiliation. Faculty appointment. Salary commensurate with qualifications. Submit curriculum vitae. Z-29, P. O. Box 2069, Philadelphia, Pa. 19103. An equal opportunity employer.

General Practitioners: We Need You. Beautiful, progressive community of Zelenople, located just 30 minutes north of Pittsburgh. Market area of 10,000. Excellent facilities, Assistance available. **T. R. MURRAY**, Zelenople Area Jaycees, Box 35, Zelenople 16063.

Psychiatrist or physician—accredited hospital. Approved psychiatric residency program, affiliated with approved general hospital. \$14,657 to \$22,768; maintenance arrangements possible. Pennsylvania license required. **R. L. GATSKI, M.D.**, Superintendent, State Hospital, Danville, Pa.



Psychiatric Residencies

Pennsylvania Hospital with outstanding teaching, therapy, research, and residencies programs and large medical staff offer fully accredited three-year training to physicians desiring certification: residencies include individual supervision of psychotherapy, experience on adolescent wards, and with patient therapy of children, college students, and adults; programs supplemented by regularly scheduled guest lecturers and three months intensive graduate lecture course at Eastern Pennsylvania Psychiatric Institute; excellent salary levels. GP Grants available; residencies beginning in January and July.

Also

Immediately available in newly constructed \$9 million "Institute for Geriatric Research" positions for Internists interested in research and General Practitioners interested in this field. Pennsylvania License necessary; excellent salary plus additional benefits.

Fringe Benefits

Liberal fringe benefits include 15 paid vacation days, 13 paid legal holidays, 15 paid sick leave days per annum; excellent retirement program; annual opportunity for meritorious salary increment; maintenance and housing available. Qualified candidates write: Superintendent, Warren State Hospital, Box 240, Warren, Pa. 16365, for details.

classified

Emergency Room physicians needed for full-time staffing. Ideal for the new graduate or for the experienced physician wishing to slow down. Write ADMINISTRATOR, Sharon General Hospital, Sharon, Pa.

Physician for Student Health Service. Easy hours, pleasant work, excellent fringe benefits. Contact H. C. PIEPER, M.D., Director, University Health Service, Lehigh University, Bethlehem, Pa. 18015. An equal opportunity employer.

House physician for 202-bed general hospital, located in a growing university community, 55 miles from Pittsburgh. Rotate services with other house physicians. Pennsylvania license required. An excellent introduction to a community with good practice opportunities. Contact ADMINISTRATOR, Indiana Hospital, Indiana, Pa. 15701.

Emergency Room physician, general practitioner, wanted for established group. Excellent guarantee and percentage. 42-hour average. City of 30,000 near Hershey Medical Center. Contact EMERGENCY OUTPATIENT ASSOCIATES, Good Samaritan Hospital, Lebanon, Pa. 17042. Telephone (717) 272-7611, Ext. 283.

Internist or general practitioner for association/partnership with established GP. Salary first year. Office next to modern, well-equipped, accredited, 140-bed general hospital. Full-time hospital-based anesthesiologist, radiologist, pathologist. Excellent working conditions with immediate hospital privileges. Progressive community in southwestern Pennsylvania on Pennsylvania Turnpike. One hour from Pittsburgh Medical Center. Excellent school system. Excellent recreation facilities, winter and summer. Write Dept. 536, PENNSYLVANIA MEDICINE.

Small general hospital in North Central Philadelphia is reorganizing the medical staff. There are openings for staff membership in departments of medicine and surgery and some chiefships of clinical services. Requirements: graduate of an approved school of medicine and licensed in Pennsylvania. Write Dept. 535, PENNSYLVANIA MEDICINE.

Internists, general practitioners, pediatricians wanted for group medical practice in inner-city Philadelphia. Prefer those interested in social change. Competitive salary, fringe benefits and faculty appointments to medical school for qualified physicians. Please contact DR. JOHN FLANAGAN, 2539 Germantown Ave., Philadelphia, Penna. 19133.

Physician Wanted—For staff of fully accredited State Hospital. Excellent fringe benefits; Civil Service position; annual salary increments; 15 days vacation; 15 days sick leave; 13 paid holidays; retirement plan; Social Security and voluntary hospitalization insurance partially paid. Pennsylvania license or eligibility. For further information, please write or call Medical Director, C. Howard Marcy State Hospital, Leech Farm Road, Pittsburgh, Pa. 15206. (412) 441-5675.

Psychiatric Residencies—Pennsylvania hospital with outstanding teaching, therapy and research programs and large medical staff offers fully accredited 3-year training to physicians desiring certification: residency includes individual supervision of psychotherapy, experience on adolescent wards and out patient therapy of children, college students and adults; program supplemented by regular scheduled guest lecturers and 3-months intensive graduate lecture course at Eastern Pennsylvania Psychiatric Institute. Excellent salary plus additional benefits. G. P. Grants available; residencies begin January and

July. Write: WARREN STATE HOSPITAL, Box 249, Warren, Pa. 16365 for details.

Wanted: House physician, Pennsylvania license, for 100-bed general hospital, suburban Philadelphia. Immediate opening, salary negotiable. Contact ADMINISTRATOR, Haverford Hospital, Havertown, Pa. 19083.

OFFICES AVAILABLE

General Practitioners—Rent-free air conditioned offices for first year. Centrally located with adequate parking. Beautiful resort area in southcentral Pennsylvania. Bedford offers an excellent practice opportunity. Small town; friendly surroundings with no big city problems. Write giving all particulars to P.O. Box 162; Bedford, Pa. 15522.

PARTNER WANTED

General practice partner wanted. Office located in southern Lancaster County. Includes all phases of medicine. Privileges available at two modern hospitals fifteen minutes from office. Terms open. Rapid partnership anticipated. ROBERT M. KEMP, M.D., 16 West Willow Road, Willow Street, Pa. 17584.

FOR RENT

Ski House for rent—Sugarbush Vermont, five bedrooms, fireplace, modern facilities, sleeps eleven, by season, month or week. Write Box 54, Ridley Park, Pa. 19078.

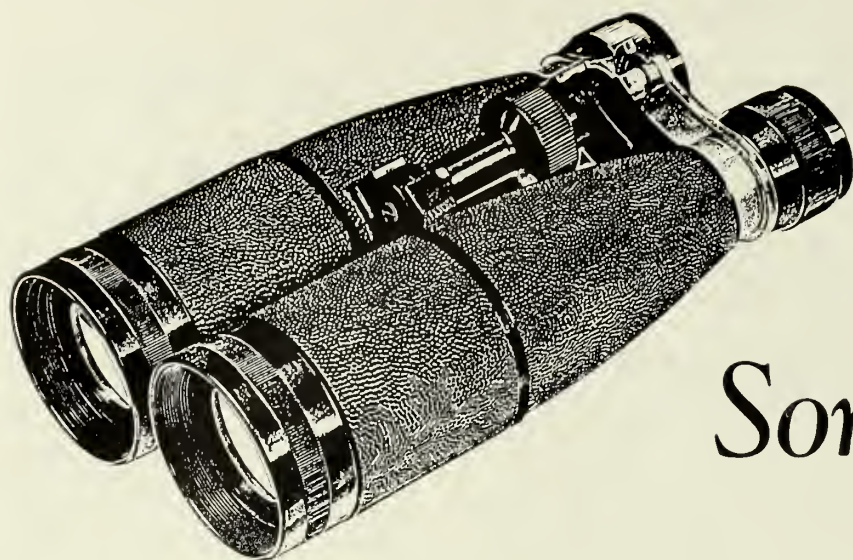
CLASSIFIED ADVERTISING INFORMATION

RATES—\$10.00 per insertion up to 30 words; 40 cents each additional word; \$1.00 per insertion for answers sent in care of Pennsylvania Medical Society. Payable in advance.

COPY DEADLINE—Copy due by the first day of month preceding month of publication. Send to Pennsylvania Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pennsylvania 17043. The right is reserved to reject or modify copy to conform with publication rules.

DEPARTMENT NUMBERS—Advertisers using department numbers forbid disclosure of their identity. Written inquiries are forwarded to such advertisers.

WORD COUNT—Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one, and "Write Department . . . , Pennsylvania Medicine," as five.



Looking
for
Something?

Try PENNSYLVANIA MEDICAL SOCIETY
PHYSICIAN PLACEMENT SERVICE

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinate of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-253-2761



PENNSYLVANIA MEDICINE

write now

Pamphlets: *Medicaid: The People's Health Plan*, 25¢ from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016. . . *Nursing Education Opportunity Grants—Information for Students*, free from the Division of Nursing, Bureau of Health Manpower, 800 North Quincy St., Arlington, Va. 22203. . . *Treating Cancer*, single copy free from Public Health Service, Washington, D.C. 20201. . . *If You Must Smoke*, single copies free from the National Clearinghouse for Smoking and Health, 4040 North Fairfax Drive, Arlington, Va. 22213. . . *Science News Communications*, \$1.50 from the National Association of Science Writers, P. O. Box H, Sea Cliff, N.Y. 11579.

Rehabilitation Monograph XXXV, Bibliography on Self-Help Devices and Orthotics, \$2.00 from Publications Office, Institute of Rehabilitation Medicine, 400 East 34th St., New York, N. Y., 10016. . . *Rehabilitation Monograph XXXVI, Rehabilitation Equipment and Devices Constructed in Wood*, \$2.00 from Publication Office, Institute of Rehabilitation Medicine, 400 E. 34th St., New York, N. Y., 10016. . . *The Most Important Thing in the World*, 25¢ from National Easter Seal Society, 2023 W. Ogden Ave., Chicago, Ill., 60612. . . *Questions and Answers, Medical Assistance, Medicaid*, 15¢ from Superintendent of Documents, Government Printing Office, Washington, D. C., 20402. . . *Easter Seal Guide to Special Camping Programs*, \$1.50 from National Easter Seal Society, 2023 W. Ogden St., Chicago, Ill., 60612.

THE PENNSYLVANIA SOCIETY OF COLON AND RECTAL SURGERY

THE ANNUAL ORATION MEETING

Friday, January 10th, 1969

Union League Club of Philadelphia
Broad and Sansom Streets
Philadelphia, Pa.

PROGRAM

MANAGEMENT OF ADENOMATOUS POLYPS OF THE
COLON AND RECTUM

GUEST SPEAKER

Neil W. Swinton, M.D., F.A.C.S.
Head of Department of Colon and Rectal Surgery
Lahey Clinic, Boston, Mass.

Cocktails: 6:30 P.M. Anniversary Dinner: 7:30 P.M.
Dress: Black Tie Preferred Guests are Most Cordially Invited

Frank H. Murray, M.D., Program Chairman,
Harry E. Bacon, M.D., Co-chairman,
Benjamin Haskell, M.D.

Kindly mail check to **Valentine R. Manning, Jr., M.D., 3336 Aldine Street, Philadelphia, Penna.**, for \$12.50 and make payable to the Pennsylvania Society of Colon and Rectal Surgery.

Robert A. McGregory, M.D., Secretary.



Gotta make a
pit stop to take
my cough syrup.

Full speed ahead,
Fred. These solid
Cough Calmers
can control that
cough for 6 to
8 hours.



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®. Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A-H-ROBINS

To fight TB- find it first!

Make tuberculin testing routine
with every physical examination.



TUBERCULIN, TINE TEST

(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



330-8/6135



Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® in two different tablet formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

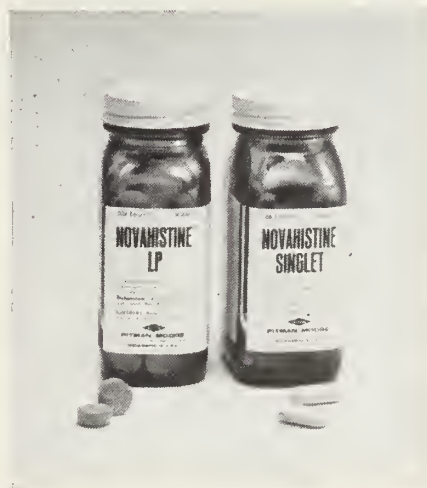
Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



An Ethical Dilemma?

Death and Heart Transplantation

Few developments in science have resulted in as much public and professional interest as the application of cardiac transplantation to man. The fears and hopes of man have long been referred symbolically to the heart and this exciting development has aroused these hopes and fears to a most unusual degree. Physicians, surgeons and scientists, like the public in general, have reacted by both condemning and applauding this latest application of scientific technology. Some hold that the unique problems introduced by the advent of heart transplantation call for the development of guidelines in the application of this new technic by collaborative discussions with men distinguished in the fields of science, theology, philosophy and the law. Others hold that no new ethical or legal problems are involved and that the medical profession alone can make all necessary decisions.

The Committee on Ethics of the American Heart Association has indicated that the ability to successfully transplant the human heart does result in unique and interrelated ethical and scientific problems. In particular, the Committee recognizes that now the tragedy of death is modified by offering the opportunity of life to someone else. It is this new relationship between death and a life-giving procedure that poses a most difficult dilemma.

Physicians by their training and experience have as their goal the preservation of human life. Accepting the

inevitability of death, physicians make every effort to delay that final outcome. Now, since not only the death of a donor, but the time when that death occurs, may offer life to another human being, some unique and difficult decisions will be required. Previously, there has rarely been any reason for haste in certifying the moment of death. One could wait until the heart stopped and all the signs of death were present and irrevocable. Now, since in the act of successful transplantation it must be possible to revive the donor heart, at what moment is it proper to say the donor is dead and his heart can be removed? The physicians' devotion to life places him in a serious dilemma particularly in identifying the moment of death in the transplant situation.

Without suggesting that life and death can ever be relegated to a committee decision, the Committee on Ethics has asked the American Heart Association to utilize the capabilities of its scientific and lay members to consider the scientific, legal and ethical aspects of heart transplantation. By such widespread consideration it will be possible to develop reasonable guidelines for the medical profession and the public in the application of heart transplantation.

Campbell Moses, M.D.

Reprinted from the Bulletin of the Allegheny County Medical Society.

Advertiser's Index

Abbott Laboratories	32, 33, 34	Obetrol Pharmaceuticals	43
Ayerst Laboratories	70, 71	Parke, Davis & Company	23
Breon Laboratories	93	Pennsylvania Society for Colon and Rectal Surgery	97
The Brown Pharmaceutical Co.	88	Pitman-Moore	98, 99
Burroughs-Wellcome	59	Poythress, Wm. P. & Co., Inc.	24
Campbell Soup Co.	81	Robins, A. H. Co., Inc.	39, 40, 97
First Investment Annuity Co. of America	51	Roche Laboratories	31, 60, 61, 4th cover
Geigy Pharmaceuticals	18, 19, 20, 21, 22, 46, 47, 48, 62, 63, 64	Rorer, Wm. H., Inc.	26
Highland Hospital	96	Sandoz Pharmaceuticals	17
Hynson, Wescott & Dunning	1	Searle, G. D. & Co.	82, 83
International Pharmaceutical Corp.	12, 13	Strasenburg Pharmaceuticals	41
Jefferson Medical College	58	The Stuart Company	101
Lederle Laboratories	3, 27, 36, 37, 42, 90, 91, 97	Vale Chemical Company	35
Lilly, Eli and Company	4, 5, 6, 52, 84, 102, 103	Warner Chilcott Laboratories	45
Medical Protective Co.	93	Warren State Hospital	94
Merck, Sharp & Dohme	85	Winthrop Laboratories	104
The National Drug Co.	25	Wyeth Laboratories, Inc.	65

the ^{In peptic ulcer:} antacid puzzle



solved by
Mylanta[®]
aluminum and magnesium hydroxides plus simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients — after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor).....	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B ₁₂ activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.).....	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate).....	110 mg.
Ascorbic Acid (Vitamin C).....	75 mg.
Folic Acid.....	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B₁₂ therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B₁₂ (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B₁₂. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B₁₂, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic

You can treat combined
deficiencies with

Trinsicon[®]

—the multifactor hematinic



Vitamin B₁₂ plus intrinsic factor (15 mcg. B₁₂ activity)—helps provide adequate levels of this important vitamin.



Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.



Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.



Iron (110 mg.)—treats hypochromic anemia.



clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon[®] (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500.

[032568]

Additional information
available to physicians
upon request.

Eli Lilly and Company,
Indianapolis, Indiana 46206.

801668

Lilly



“The inconvenience of a cold”

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

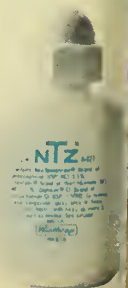
NTZ is more than a simple vasoconstrictor. It contains **Neo-Synephrine®** (brand of phenylephrine)

HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadin® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

Winthrop Laboratories, New York, N.Y. 10016



Winthrop

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

Publisher: File two copies of this form with your postmaster.

Postmaster: Complete verification on page 2

Form Approved,
Budget Bureau No. 46-R029

1 DATE OF FILING	2 TITLE OF PUBLICATION	
September 18, 1968	PENNSYLVANIA MEDICINE	
3 FREQUENCY OF ISSUE		
Monthly		
4 LOCATION OF KNOWN OFFICE OF PUBLICATION (Street, city, county, state, ZIP code)		
Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043		
5 LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS (Not printers)		
Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043		
6 NAMES AND ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR		
PUBLISHER (Name and address)		
Penna. Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pa. 17043		
EDITOR (Name and address)		
Carl B. Lechner, M.D., 4111 Beech Avenue, Erie, Pennsylvania 16508		
MANAGING EDITOR (Name and address)		
Thomas J. McCaghren, Taylor Bypass and Erford Road, Lemoyne, Penna. 17043		
7. OWNER (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.)		
NAME	ADDRESS	
Penna. Medical Society	Taylor Bypass and Erford Road	
	Lemoyne, Pa. 17043	
8. KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES (If there are none, so state)		
NAME	ADDRESS	
Cumberland County National Bank	New Cumberland, Pennsylvania	
9. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES (Section 132.122, Postal Manual)		
(Check one)		
The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes	☒ Have not changed during preceding 12 months ☐ Have changed during preceding 12 months	
	(If changed, publisher must submit explanation of change with this statement.)	
10. EXTENT AND NATURE OF CIRCULATION	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	SINGLE ISSUE NEAREST TO FILING DATE
TOTAL NO. COPIES PRINTED (Net Press Run)	13,600	13,700
PAID CIRCULATION		
1. SALES THROUGH DEALERS AND CARRIERS, STREET VENDORS AND COUNTER SALES	---	---
2. MAIL SUBSCRIPTIONS		
Non-members-- 389		
Members incl'd in dues-12,211	12,590	12,600
TOTAL PAID CIRCULATION	12,590	12,600
FREE DISTRIBUTION (including samples) BY MAIL, CARRIER OR OTHER MEANS	860	875
TOTAL DISTRIBUTION (Sum of C and D)	13,450	13,475
OFFICE USE, LEFT-OVER, UNACCOUNTED, SPOILED AFTER PRINTING	150	225
TOTAL (Sum of E & F--should equal net press run shown in A)	13,600	13,700

I certify that the statements made by me above are correct and complete.

(Signature of editor, publisher, business manager, or owner)



Thomas J. McCaghren

Whenever anxiety induces or intensifies clinical symptoms

Librium[®]

(chlordiazepoxide HCl)

*Quickly relieves anxiety~Helps improve response in
psychophysiologic disorders~Seldom impairs
mental acuity or physical coordination, on proper dosage~
Has wide margin of safety*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing

gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly

and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs[™] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche[®]

LABORATORIES

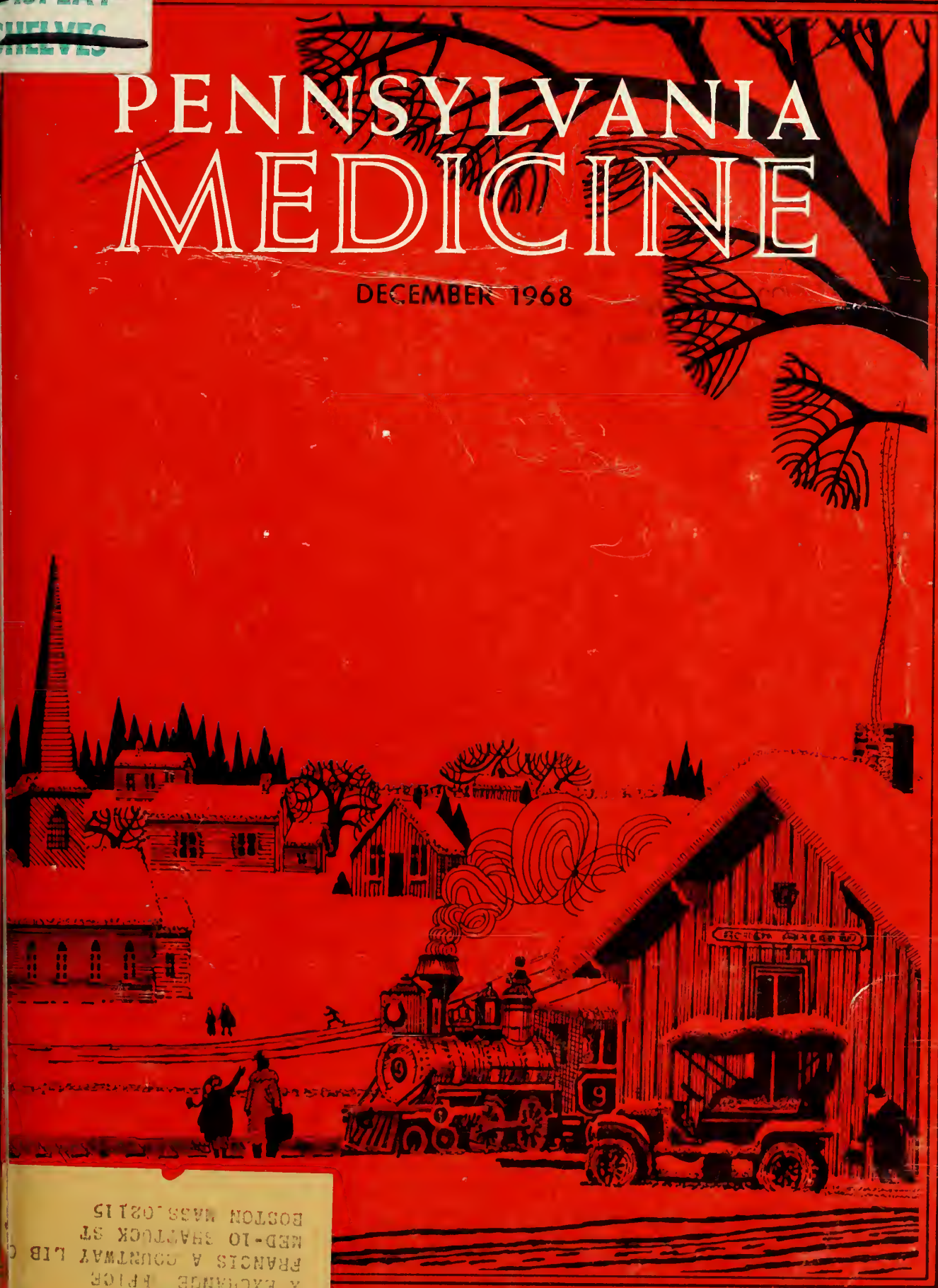
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Also available: Libritabs[™] (chlordiazepoxide) 5-mg, 10-mg, 25-mg table.

DISPLAY
SHELVES

PENNSYLVANIA MEDICINE

DECEMBER 1968



FRANCIS & TOWNSEND LIB
MED-10 SHAWLOCK ST
BOSTON MASS 02115

TOM MCCAQHRN

Home From Medical School

Your Tribute of Thanks

Many of the members of your County Medical Society may not be aware of a very valuable, free service that is benefiting you and your associates right in your own community.

Isn't it about time that recognition be given to the unsung heroes of your town—the health volunteers who work unselfishly without remuneration for the betterment of their fellow man? How can your County Medical Society appropriately express the cumulative gratitude of you and your colleagues to the health volunteers in your area?

One of the finest and most important tributes of thanks your County Medical Society can make to those performing "above and beyond the call of duty" is the presentation of a Benjamin Rush Award. The award is a good public relations tool, too, because it is especially designed to create public awareness of individuals and groups who have made outstanding voluntary contributions to the health and welfare of the people of your county.

Today is the day for you to reach for the phone and call your County Medical Society. Urge them to consider, now, selecting a Benjamin Rush Award winner from your community. And, when your county winner has been selected, be sure that this winner is submitted as a nominee for the statewide competition.

The deadline for the state society award nomination is February 1, 1969. Your county may nominate to the state competition past years' winners of your county awards in addition to current winners. Just be sure that the nominations with supporting materials are sent in time to reach the state society headquarters in advance of the deadline date.

The Benjamin Rush Award program is endorsed by your House of Delegates as a valuable instrument with an ability to bring your community closer to your county and state society activity. Every effort should be made to give it the attention it deserves by giving recognition to deserving health volunteers.

Want more information on selecting winners from your area? Remind your County Medical Society officials that a Benjamin Rush Award program kit is available simply by sending a post card to the Pennsylvania Medical Society Council on Public Service. You'll be in business by return mail.

COUNCIL ON PUBLIC SERVICE





PENNSYLVANIA
MEDICINE

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE

/medigram

DEC 1968

MASS IMMUNIZATION BILL SHELVED UNTIL JANUARY

The bill to give physicians and nurses immunity from ordinary negligence when serving on mass immunization programs (S-1673) could not be acted on by the State House of Representatives on the final day of its session last month because several House members insisted on debate. These members also would have requested a "slow roll call" which would have killed the bill because there were only 87 representatives present (five of these known to be opposed)--not enough for a constitutional majority of 105. Pennsylvania Medical Society, not wanting the bill to be voted down, preferred the House take no action, but drop the bill from the calendar for re-introduction at the beginning of the new session in 1969. PMS produced evidence to House members showing that malpractice insurance coverers were not willing to sell more new insurance. The impact this evidence made toward support of the bill would have assured certain passage had there been a "full house."

SENATE DEFEATS COUNTY HEALTH DEPARTMENT REFERENDUM BILL

A bill, introduced by Senators Clarence Bell and Clyde Dengler of Delaware County, which would prohibit a county health department referendum from being held for five years after it is defeated was voted down in the final week of political activity on Harrisburg's Capitol Hill. The bill was defeated 23-23 with most of the Republicans siding with the two sponsors of the bill. However, PMS was instrumental in getting the entire Democratic caucus to vote against the bill, along with the support of three Republican senators - Albert Pechan, Marvin Keller and Wilmot Fleming. The Delaware County Medical Society sponsored a county health unit referendum this past election and lost. The county society was quite anxious to have this bill (S-1801) defeated because of its plans to conduct a new referendum at the next primary election. The bill fell for lack of a constitutional majority of 26 in the Senate, although the two Delaware County senators persisted by requesting the bill be reconsidered. It may well be introduced at the next legislative session in January.

UNION STARTS INSURANCE DRIVE

Walter Reuther's United Auto Workers have started a well-financed drive to establish a national health insurance scheme and have named a committee of nationally known persons to support their goal. Committee members include Michael DeBakey, M.D., and philanthropist Mary Lasker who has been a potent force in Washington for years.



PMS PRODUCES TV, RADIO SPOTS ON HOLIDAY SAFETY

Home decorating,
fires, and toy-
caused accidents

are among the hazards pointed out in safety materials prepared by the Council on Public Service for release during this holiday season. A thirty-second, color TV spot will emphasize the need for keeping freshly cut trees watered to prevent drying out; to locate them away from the wall; trimming them with the aid of a good step ladder and checking tree light circuits ahead of time so that faulty wires can be replaced. This public

service announcement is being released to all TV stations in the Commonwealth during the first week of December. Radio safety messages will include a one-minute spot on snow shoveling by Gerald S. Backenstoe, M.D., Emmaus; holiday decorating hazards by Joseph M. Garfunkel, M.D., Harrisburg; toy-caused accidents by David W. Kline, M.D., Greenville; home fires by Jack C. White, M.D., West Chester; and children vs. escalators by Kenneth L. Cooper, M.D., Williamsport.

PMS DEVELOPING SMALL COMMUNITY HOSPITAL EDUCATION PROGRAM

The PMS Council on Education and Science is developing a statewide educational program to bring con-

tinuing medical education to small community hospitals lacking this service. An offering of ten different courses (1. shock, fluids, electrolytes; 2. infections, antibiotics; 3. pediatric problems; 4. OB-GYN problems; 5. treatment of recurrent or metastatic cancer; 6. cardiovascular disease; 7. gastrointestinal disease; 8. genitourinary disease; 9. diseases of the nervous system and 10. laboratory diagnosis-updated) would be given on a west-central-east regional basis with a traveling staff of instructor specialists from those respective areas teaching in a hospital conveniently located within each of the 23 districts to be serviced. Funds for the program are expected to be acquired through pharmaceutical firms' postgraduate educational grants.

RUBELLA VACCINE PRESSURE GROWS

With excellent results from the clinical trials, manufacturers

are in the process of mass producing the new Rubella vaccine amid growing pressures for a government supported mass immunization campaign. The vaccine is expected to be approved and ready for distribution by March or April.

PREPAID GROUP COSTS RISE

One of the nation's big prepaid group practice plans, New York's Health Insurance Plan, has filed with the state insurance commission for rate increases of nearly 40 per cent. It's a blow to federal officials who have been touting prepayment plans.

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®

SODIUM SULFOBROMOPHTHALEIN®

**IN A COMPLETE,
STERILE,
DISPOSABLE,
& ECONOMICAL
PATIENT-UNIT.**

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

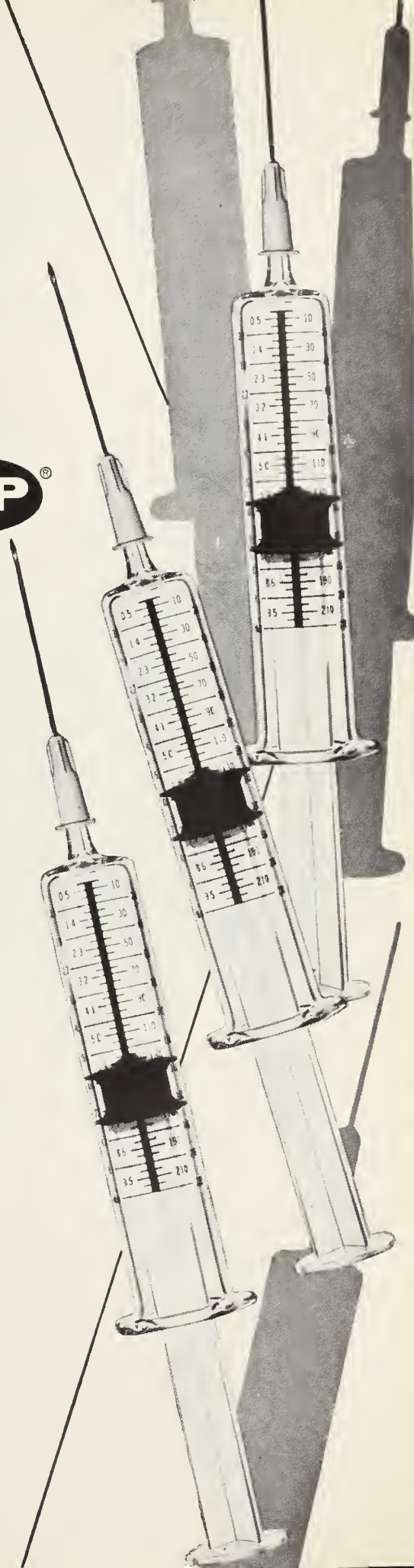
This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

LYNCH, WESTCOTT & DUNNING, INC.



(89003)

BALTIMORE, MARYLAND 21201



PENNSYLVANIA MEDICINE®

© 1968 Pennsylvania Medical Society

The Pennsylvania Medical Journal
Official Publication of the Pennsylvania Medical Society

DECEMBER, 1968

VOLUME 71, NUMBER 12

ORIGINAL PAPERS

Blowout Fractures of the Orbit	37
Thermography as an Investigative Technique	38
Diagnosing Corneal Disease	41

FEATURES

OEO Neighborhood Health Centers—The Poor and You	44
Postgraduate Training in Sports Medicine	46

NEWSFRONTS

PMS 1968 Scientific Session—Pictorial Review	4
Nation's First Air Pollution Monitoring System Inaugurated by Allegheny County Health Dept. . .	13
Carl Kuehn, M.D., Appointed Commonwealth's Deputy Secretary for Local Health	14
Student Admission Studied by Six Philadelphia Medical College Deans	17
Closeup/M.D.'s	25
Capitol Report	32

EDITORIALS

OEO Health Centers—The Poor and You	33
Thy Staff	33

SCIENTIFIC REPORTS

Cardiovascular Briefs	53
Cancer Forum	68

GENERAL

Continuing Education	57
Obituaries	66
Write Now	69
Meetings	70
Classified	72
In My Opinion	76
Advertiser's Index	76

PUBLISHED MONTHLY BY THE
PENNSYLVANIA MEDICAL SOCIETY
TAYLOR BYPASS AND ERFORD ROAD,
LEMOYNE, PENNSYLVANIA 17043

Subscription \$5.00 Single Copy 50¢

PUBLICATION COMMITTEE

H. Thompson Dale, M. D., State College,
Chairman
D. George Bloom, M.D., Johnstown
William J. Kelly, M.D., Pittsburgh
Robert S. Sanford, M.D., Mansfield
Ralph K. Shields, M. D., Bethlehem

STAFF

Carl B. Lechner, M.D., 4111 Beech Avenue,
Erie 16508—Medical Editor
David A. Smith, M.D., Polyclinic Hospital,
Harrisburg 17105—Associate Medical
Editor
Thomas J. McCaghren, Taylor Bypass and
Erford Road, Lemoyne 17043—Man-
aging Editor
Mary L. Uehlein, Taylor Bypass and Er-
ford Road, Lemoyne 17043—Editorial
Assistant

CONTRIBUTING EDITORS

Harry E. Bacon, M.D., Philadelphia
William C. Beck, M.D., Sayre
Walter I. Buchert, M.D., Danville
Lewis T. Buckman, M.D., Wilkes-Barre
A. Reynolds Crane, M.D., Philadelphia
Garfield G. Duncan, M.D., Philadelphia
Mario N. Fabi, M.D., Scranton
George H. Fetterman, M.D., Pittsburgh
Wendell B. Gordon, M.D., Pittsburgh
Samuel B. Hadden, M.D., Philadelphia
Jack D. Myers, M.D., Pittsburgh
William Likoff, M.D., Philadelphia
Eugene P. Pendergrass, M.D., Philadelphia
Mary DeWitt Pettit, M.D., Philadelphia
Sydney E. Sinclair, M.D., Camp Hill
David A. Smith, M.D., Harrisburg
James R. Watson, M.D., Pittsburgh

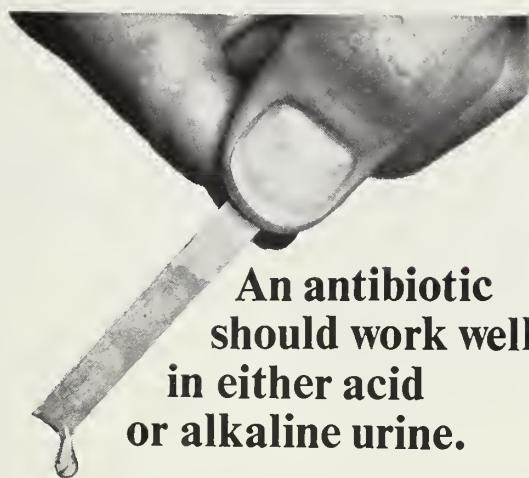
• **GENERAL.** Established 1897. Penn-
sylvania Medicine may not be held re-
sponsible for opinions expressed in any
of its contents.

• **EDITORIAL.** Address all original
papers, features, and editorial corre-
spondence to the Managing Editor.

• **ADVERTISING.** Pennsylvania Medi-
cine's advertising policy conforms with
principles governing advertising in
American Medical Association scientific
publications. National advertising rep-
resentatives: State Medical Journal Ad-
vertising Bureau, Inc., 510 North Dear-
born Street, Chicago, Illinois 60610.
Advertising rates on request to Penn-
sylvania Medicine office, Taylor Bypass
and Erford Road, Lemoyne, Pennsylvania
17043, or the SMJAB. For classified
rates, see classified section.

• **MAILING.** Second-class postage paid
at Lemoyne, Pennsylvania.

• **CHANGE OF ADDRESS.** Give name,
old address, new address (include ZIP
number), state if change is permanent
or temporary. Send notice to Penn-
sylvania Medicine, Taylor Bypass and Er-
ford Road, Lemoyne, Pennsylvania
17043. Allow six weeks for change of
address.



**An antibiotic
should work well
in either acid
or alkaline urine.**

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system — anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin — maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney — rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated — 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York



PMS 1968 Scientific Session

Chatham Center, Pittsburgh, October 27-29



Luncheon Session—Speaking on *Electrolyte Complications of Diuretic Therapy* are (left to right) Discussion Chairman Jerome Chamovitz, M.D., Sewickly, member, PMS Committee on Convention Program, and Participants Sheldon Adler, M.D., Montefiore Hospital, Pittsburgh, and David P. Lauler, M.D., director, endocrine-metabolic unit, Peter Bent Brigham Hospital, Boston.



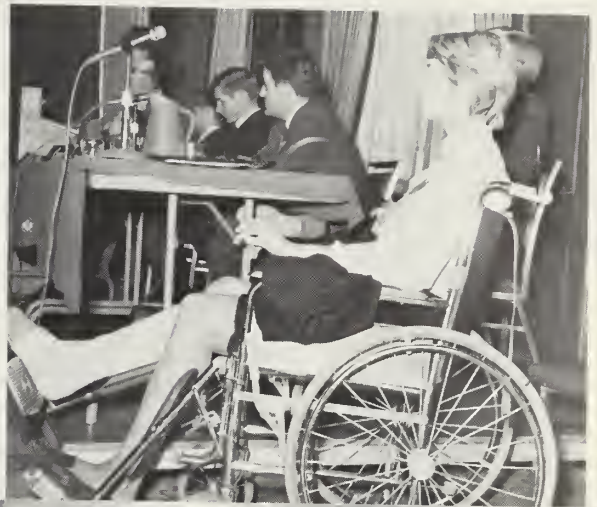
The Group—Discussing their program before beginning the evening session on *Group Practice* are (left to right) Speakers James A. Collins, Jr., M.D., Geisinger Medical Center, Danville; Allen W. Cowley, M.D., Harrisburg; Richard Magraw, M.D., Department of Health, Education and Welfare, Washington, D.C.; and Session Chairman George E. Farrar, Jr., M.D., president, Pennsylvania Medical Society.

Congestive Heart Failure—In discussion during the session on *Water and Sodium in Health and Illness* are (left to right) Panelists John H. Moyer III, M.D., professor, department of medicine, Hahnemann Medical College and Hospital; T. S. Danowski, M.D., professor of medicine, University of Pittsburgh School of Medicine; J. Bernard L. Gee, M.D., University of Pittsburgh School of Medicine, and Moderator Martin Goldberg, M.D., chief, renal-electrolyte section, department of medicine, University of Pennsylvania School of Medicine.

Distinguished Visitors—More than 650 nurses and student nurses from the Commonwealth and from Ohio, West Virginia, New York and New Jersey attended the Seminar on *Renal Diseases for Nurses and Allied Professionals*.



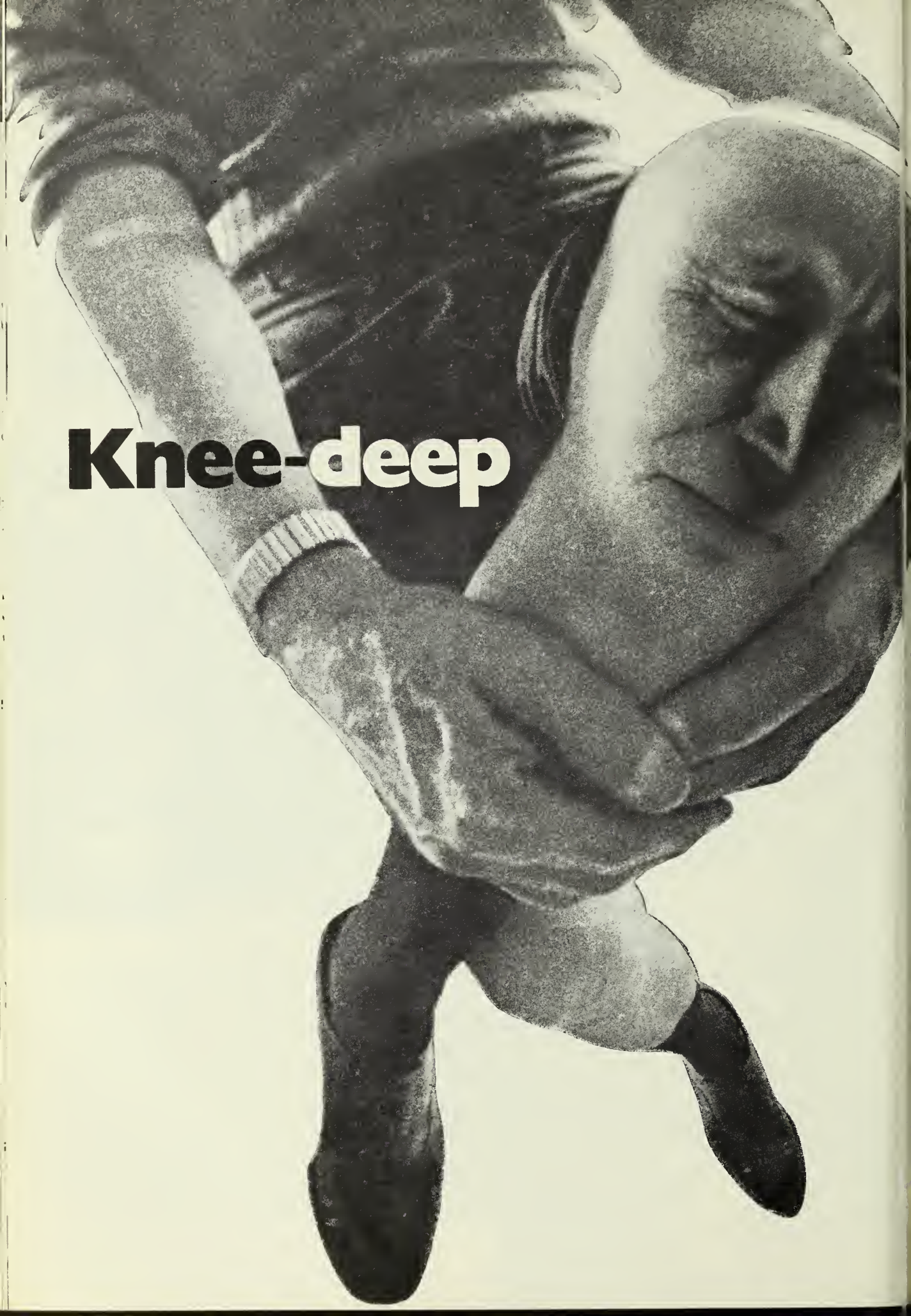
Lady in Waiting—Christina Comty, M.D., assistant professor of medicine, University of Pittsburgh School of Medicine, awaits her turn at the podium to speak on the subject of *The Selection of Patients during the Seminar on Renal Diseases for Nurses and Allied Professionals*.



Wares of the Profession—The exhibit area featuring pharmaceutical, office equipment and service organization displays were visited by hundreds of guests daily during session breaks.



Evening Session—Discussing the Status of Organ Transplantation during a meeting open to the general public are (left to right) Panelists Holbrook Bunting, Jr., attorney, Pepper, Hamilton & Scheetz, Philadelphia; Seward Hiltner, Ph.D., professor of theology and personality, Princeton Theological Seminary, Princeton, N.J.; Jacques L. Sherman, Jr., M.D., medical director, Maimonides Medical Center, Brooklyn, N.Y., and Paul B. McCleave, LL.D., director, department of medicine and religion, American Medical Association.



Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearyl.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearyl usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearyl.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearyl[®]
oxyphenbutazone

Tandearyl, oxyphenbutazone:
For brief summary see next page.

Geigy



Tandearil[®]

oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discon-

tinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

 Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Dilantin[®]

(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anti-convulsant drugs.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. **ADVERSE**

REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred. DILANTIN is supplied in several forms including Kapseals[®] containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.

Parke, Davis & Company, Detroit, Michigan 48232

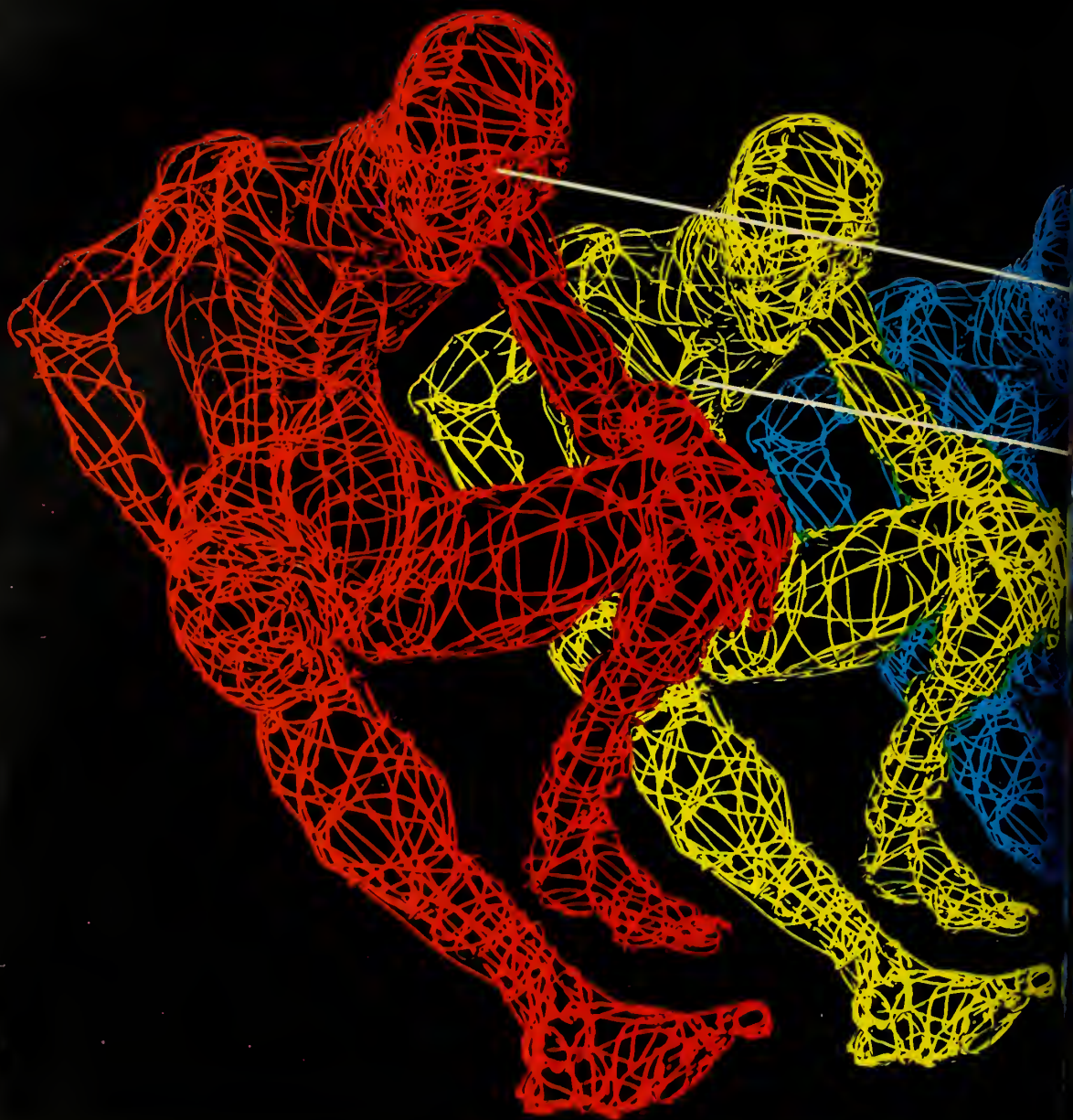
The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS

015R47



a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor).....	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B ₁₂ activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.).....	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate).....	110 mg.
Ascorbic Acid (Vitamin C).....	75 mg.
Folic Acid.....	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

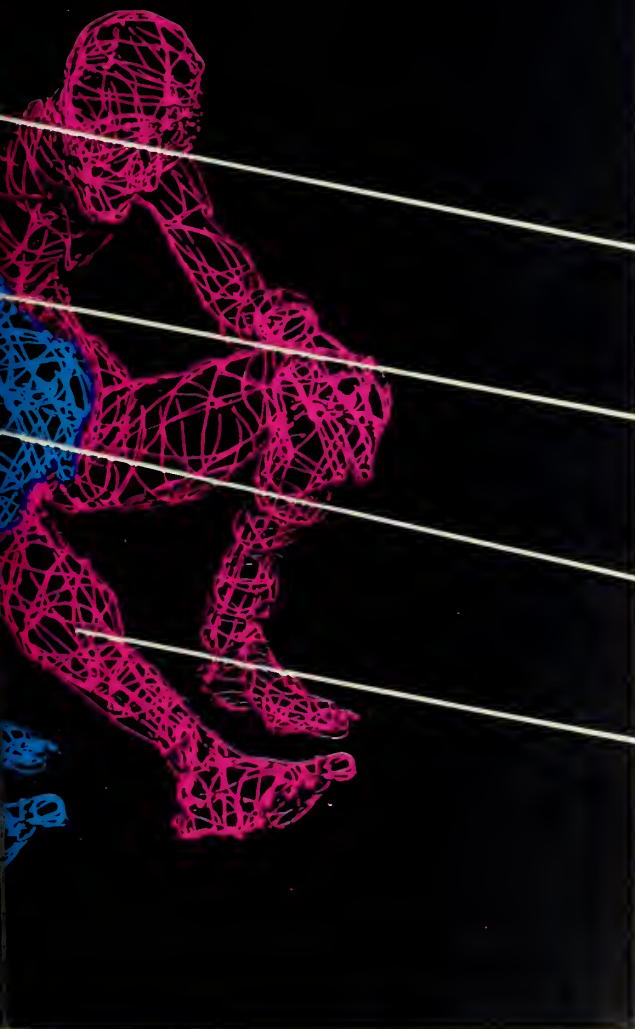
In pernicious anemia, the use of folic acid without adequate vitamin B₁₂ therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B₁₂ (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B₁₂. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B₁₂, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic

You can treat combined
deficiencies with

Trinsicon[®]

—the multifactor hematinic



Vitamin B₁₂ plus intrinsic factor (15 mcg. B₁₂ activity)—helps provide adequate levels of this important vitamin.



Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.



Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps Iron absorption.



Iron (110 mg.)—treats hypochromic anemia.

cal and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

Supplied: Pulvules Trinsicon[®] (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500.

[032560]

Additional information
available to physicians
upon request.

Eli Lilly and Company,
Indianapolis, Indiana 46206.

801668

Lilly

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.^{1,2} For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:

1 Bed "If the patient is in the pain-spasm-cycle... there is no alternative or substitute for absolute bed rest..."³

2 Board "Boards should be ordered under the mattress... these boards act by immobilizing the spine..."⁴

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."⁵

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated⁶ skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."⁷ And there is little likelihood of sedation.⁶

Indicated for relief of skeletal muscle spasm. Contraindicated in hypersensitive patients. Side Effects (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. Also available: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)
References: (1). Gadsby, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: South Dakota J. Med. 18:26, 1965. (5). Sata-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., et al.: New York J. Med. 62:1985, 1962.

A-H-ROBINS A. H. ROBINS COMPANY
RICHMOND, VIRGINIA 23220

Allegheny County Monitors Air Pollution

The heavy industrial area of Pittsburgh took a giant stride toward the control of pollutants with implementation of a county-wide network of telemetering stations hooked directly to a computer.

The network—the first “on-line” air pollution monitoring system in the United States—will provide the Allegheny County Health Department with up-to-the minute information on levels of pollution at any point in the county at any time.

This, in turn, will allow the department's bureau of air pollution control ample time to advise residents of potentially dangerous situations, and to recommend effective counter-measures.

When fully operational within two years, the new computer-based network will be comprised of 103 continuous-monitoring sensor devices at eighteen remote locations. Each station will be directly linked by telephone lines to an IBM 1800 data acquisition and control system at the Arsenal Health Center here.

At present, two of the stations are operating—one in the Allegheny County Courthouse downtown, and the other in the city's Hazelwood section. Seven more are scheduled to go into service within six months.

Prior to implementation of computerized monitoring of pollutants, air pollution in Greater Pittsburgh was measured through the use of an electro-mechanical device which recorded information on unwieldy, six-foot long strip charts. A total of eleven such charts were read daily—a number which would have increased to 103 with the planned expansion of the system.

Edward L. Stockton, chief of the bureau of air pollution control, views initiation of the sophisticated system as “yet another major step forward in this field by Allegheny County.

“We intend to become the nation's leader in protecting the health of our citizens against polluted air through effective utilization of this computer-based system.

“We will be able to measure peak conditions of pollution at the exact times when accurate evaluation may be absolutely essential in guarding



Sensing Device—Atop a roof in the steel and coke-producing Hazelwood area of Pittsburgh provides the Allegheny County Health Department's IBM 1800 data acquisition and control system with a continuous flow of information on the levels of various air pollutants.

against harmful inversions or stagnations of air.”

He explained that the air pollution control bureau will have the ability to immediately recommend certain actions as soon as it becomes evident that a dangerous situation exists. These actions might include urging residents to:

- Leave cars at home and take public transportation to and from work.
- Refrain from burning trash and other materials outdoors.
- Generate power for essential industry outside the area of concern or use alternate sources of power.

—Cutback industrial operations for the period of concern.

The new IBM-anchored system is designed to measure and evaluate twelve aspects of air pollution and meteorology, including sulfur dioxide, hydrogen sulfide, carbon monoxide, hydrocarbons, aldehydes, fine particulates, wind speed and direction, air temperature, solar radiation, oxides of nitrogen and total oxidants.

Air pollutants enter sensing instruments through probes at each of eighteen county-wide locations. The particles are analyzed, and the readings are then transmitted as electrical signals over telephone lines to the IBM 1800 at the Arsenal Health Center.

The computer isolates and prints out maximum readings from each remote location. It then averages readings a minimum of once per minute. This gives the average condition over any specified period. Total findings are printed out in engineering units, to be interpreted by the bureau staff.

A typical final printout—which will describe the level of pollution in terms of parts per million at any given air temperature—also will list the pollution level of all twelve atmospheric conditions at each of the eighteen remote locations.

“Use of the IBM 1800 in concert with remote telemetering allows us to both log and analyze data at one central location for the entire area—the first such installation in the nation where this is possible,” Mr. Stockton said.

Coronary Care Unit Opens At Einstein

A new, \$90,000, five-room Coronary Care Unit was ready to receive patients Oct. 28, 1968 at Philadelphia's Albert Einstein Medical Center.

Pascal F. Lucchesi, M.D., Einstein's executive vice president and medical director, said the coronary care unit has been fitted with the latest available electronic monitoring and sophisticated life-sustaining devices.

New Health Deputy Appointed

Governor Raymond P. Shafer has announced the appointment of Carl C. Kuehn, M.D., as Deputy Secretary for Local Health in reorganizational changes in the State Department of Health.

For the first time in recent years, the Department of Health will have three deputy secretaries. Richard J. Potter, M.D., was appointed a deputy in September with major administrative responsibilities in health and program services under Secretary of Health Thomas W. Georges, Jr., M.D. Wesley E. Gilbertson was appointed as Deputy Secretary for Environmental Protection. Dr. Kuehn and Mr. Gilbertson report to Doctor Potter.

"With enlarged responsibilities for Dr. Kuehn and Mr. Gilbertson as deputy secretaries," Gov. Shafer commented, "the Department of Health will have the flexibility it needs to continue meeting the challenges in this ever-changing field."

"These reorganizational steps will make for more effective administration for our direct-service health programs and help to identify our total environmental protection program in this administration's all-out effort to make Pennsylvania a healthier, better place in which to live."

Director of the Bureau of Field Services since 1954 and acting Deputy Secretary of Local Health, Dr. Kuehn will have overall responsibility for the Commonwealth's regional health functions with special emphasis on the establishment of local county health units.

Jefferson Runs State Institution

Jefferson Medical College has taken over the responsibility for staffing and running a 600-bed mental hospital—to be called the Jefferson Medical College Unit of the Philadelphia State Hospital at Byberry, Philadelphia. This is the first time in American medicine that a medical college has entered so extensively into the running of a state mental institution.

First Pennsylvanian

Akron M.D. Elected To Top AAGP Post

Edward J. Kowalewski, M.D., is president-elect of the nation's second largest medical association, the American Academy of General Practice. He is the first Pennsylvanian to hold this high post.

The 48-year old Akron physician was elected at the academy's annual convention in Las Vegas this year, and will be installed at the 1969 convention, scheduled for Philadelphia. It will mark the first time that a president of the association has been installed in his home state.

Dr. Kowalewski, a member of a three-man general practice in the Lancaster County community, has a long history of civic and professional activity. Most recently he received the 1968-69 *Medical Tribune* Auto Safety Award which has been given annually since 1961 for "lifesaving achievement in the service of health." His successful efforts to have a median barrier installed along the entire Pennsylvania Turnpike brought him this award, as reported in the August issue of *Pennsylvania Medicine*. He launched the successful campaign in 1960, and stayed with it until the entire 359-mile strip was completed in 1964. The PMS Voice of Medicine award also was bestowed on Dr. Kowalewski in 1968.

In medical affairs, he has served the American Academy of General Practice in several posts, including Chairman of the Board of Directors in 1967-68. He is a past president of the Pennsylvania Academy of General Practice, and was spokesman for general practitioners on the Governor's Committee for Study and Report on Pennsylvania's Health, in 1961.

Dr. Kowalewski is founder and past president of the Lancaster County

Academy of General Practice and served as president of the Lancaster County Medical Society in 1964. He is a founder of the Ephrata Community Hospital, and was selected by the State Department to tour Iron Curtain countries representing the typical United States family physician.

The president-elect of the "largest medical specialty group in the nation" has expressed interest in the "family practice" concept, by which medical students will be trained to treat entire families through additional studies in medical school. Dr. Kowalewski has said he has expectations that the American Medical Association soon will create a Board of Family Practice to oversee the concept as it is being forwarded in medical schools throughout the nation, including Temple University School of Medicine.

Centers to Provide Psychiatric Care, Health Official Says

"Psychiatrists will be brought to the people who need them in mental health centers," stated James R. Harris, M.D., director of the Community Mental Health Center and of the Community Health Center of the Pennsylvania Hospital.

Dr. Harris made his remarks as guest speaker in the first of a series of eight lectures on applied psychiatry sponsored by the Pennsylvania Academy of General Practice and the Department of Psychiatry at The Geisinger Medical Center.

Dr. Harris, also associate professor of psychiatry at the University of Pennsylvania, pointed out that psychiatrists tend to practice in wealthy metropolitan neighborhoods and, as a result, 90 percent of the psychiatry care is available to only 10 percent of the country's population.

The answer to the problem is the network of community mental health centers, of which Geisinger's will be one, throughout the U. S., each responsible for psychiatric care for 300,000 people in its immediate area.

Even with the network of centers, there will not be sufficient psychiatrists available, according to Dr. Harris, but "general practitioners, nurses, the clergy, pharmacists and welfare workers will become a part of the psychiatric team."

Escape to the warm sunshine of South America! Our South American Adventure is a once in a lifetime chance to make your vacation dollars go farther than you believed possible . . . all the way to three of South America's most exciting capitals — QUITO . . . BUENOS AIRES . . . RIO DE JANEIRO.

It's your vacation — plan each day yourself! Choose from optional daily sightseeing tours, shop, bask in the sun, golf, nightclub or relax whenever you please for two fun filled weeks!

It's a completely new way to travel to South America — nonregimented!

LEHIGH COUNTY MEDICAL SOCIETY TRAVEL SEMINAR FOR
MEMBERS, FAMILIES, FRIENDS OF PENNSYLVANIA MEDICAL SOCIETY

SOUTH AMERICAN ADVENTURE



\$798

Complete

Depart
PHILADELPHIA
and
PITTSBURGH
MARCH 15, 1969

RETURN THIS COUPON NOW!

Send to: LEHIGH COUNTY MEDICAL SOCIETY
335 N. 8th Street, Allentown, Pa. 18102

Enclosed is my check for \$_____ (\$100 per person) as deposit. Final payment is due 60 days before departure. Make check payable to: Manchester Bank — South American Adventure Trust Account.

NAME _____

PHONE _____

ADDRESS _____

CITY

STATE

ZIP

MAKE YOUR RESERVATIONS NOW — SPACE STRICTLY LIMITED!

Speakers' Bureau Training Seminar



Effective Communication—David A. Smith, M.D., chief of medical service, Harrisburg Polyclinic Hospital, and associate medical editor, *PENNSYLVANIA MEDICINE*, was among twenty state society officers, members of the PMS Speakers' Bureau, and selected staff personnel to watch themselves in action on a television monitor during the Speakers' Bureau Training Seminar conducted last month

at the PMS headquarters in Lemoyne. The one and one-half day seminar, taught by a specially trained AMA staff, offered the latest techniques on how to prepare and give convincing talks and answer questions from the audience. Each student delivered a brief address which was recorded on videotape for later playback and critique.

York Hospital Sponsors Clinical Studies Program

A series of thirty half-day weekly seminars designed to keep central Pennsylvania's practicing physicians abreast of the latest developments in medical science and technology has begun at York Hospital.

This series provides attending physicians, hospital resident physicians, interns and medical students with advanced clinical concepts from major research and medical teaching centers.

According to Robert L. Evans, M.D., director of York Hospital's medical education department, a prime objective of this series is to encourage a free interchange of ideas and to provide physicians with practical material that can be useful in their practice of medicine.

These seminars were started in 1960 as a continuing hospital program for physicians. The Jefferson Medical College, Pennsylvania State University and York Hospital jointly sponsor this affair.

Authorities from eastern United States schools of medicine and comprehensive hospital centers will discuss the latest advances in medicine. Subjects include heart disease, sex education, drugs, and psychiatry.

Many of the prominent medical

lecturers will spend two days at York Hospital conducting conferences and discussions as well as teaching new techniques.

The seminars are held every Thursday morning at the hospital's Marie Ketterman Nursing Home auditorium.

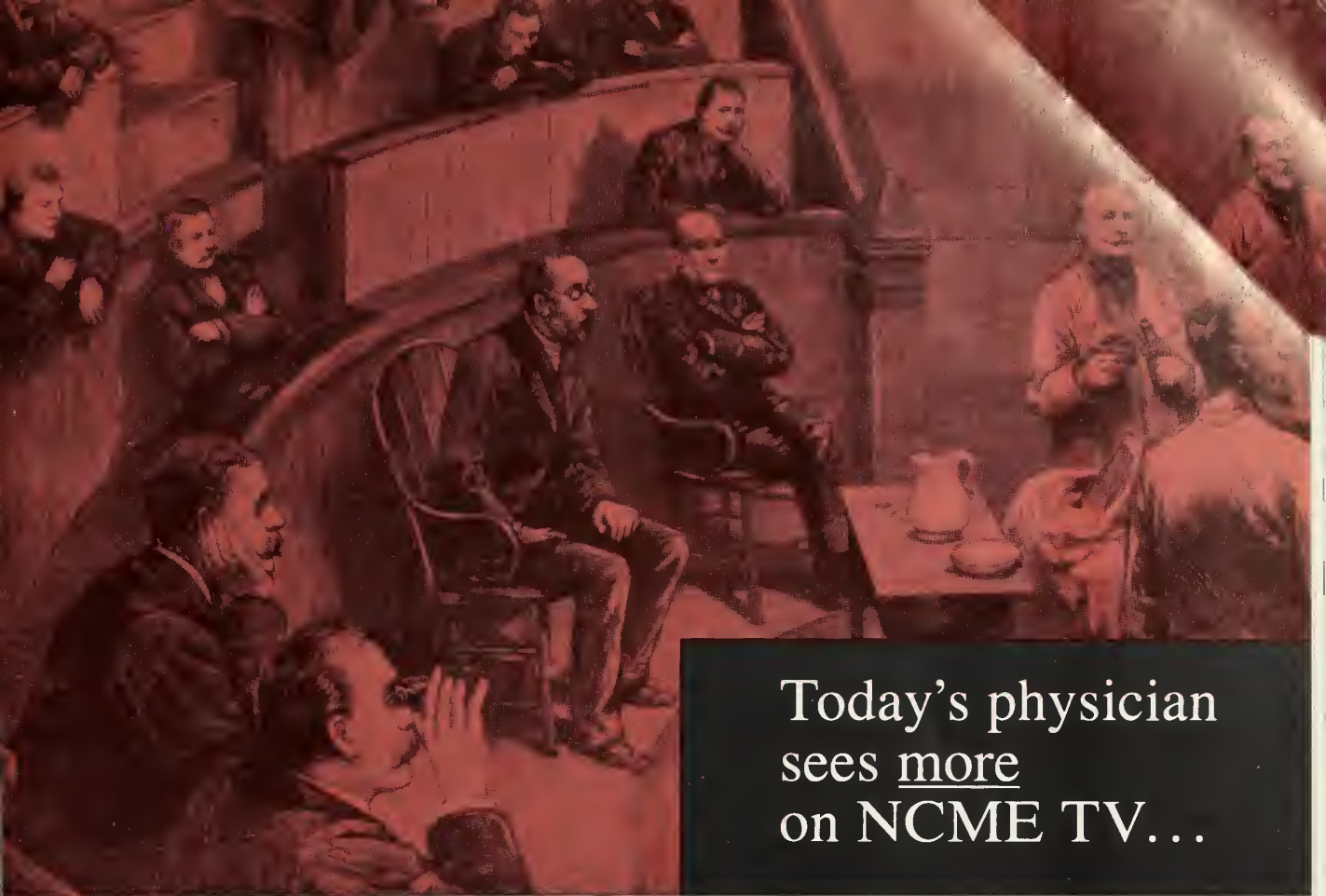
TV, Blue Cross Officials Elected To State Health Council Posts

Peter W. Duncan of Ardmore was elected chairman and Richard D. Rife of Camp Hill vice-chairman at the organizational meeting of the Pennsylvania Advisory Council for Comprehensive Health Planning appointed recently by Governor Raymond P. Shafer.

Duncan is editorial director for

station WCAU-TV in Philadelphia, and Rife is president of Capital Blue Cross.

At the meeting, the new council discussed in broad terms the proposed program for Pennsylvania's comprehensive health planning in 1969 as outlined by federal "Partnership for Health" legislation.



MANN ARCHIVE

Today's physician sees more on NCME TV...

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME

The Network
for Continuing
Medical
Education

NCME TV Offers These Practical Benefits:

- ☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.
- ☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.
- ☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.
- ☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.
- ☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N. Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N. Y. 10017

Admission Plans Studied By Six Medical Deans

The deans of six medical colleges in Philadelphia are creating two special task forces, including students and community leaders, to help solve problems connected with admitting more black and disadvantaged students to medical schools.

The deans announced their plans at a news conference called to answer a demand by a student group, "The Committee for Black Admissions." Earlier the committee had called for increasing the number of black students to one-third of the next freshman class.

The statement was made by deans from Hahnemann Medical College, Jefferson Medical College, The University of Pennsylvania School of Medicine, Temple University School of Medicine, Woman's Medical College of Pennsylvania and the Philadelphia College of Osteopathic Medicine.

The spokesman for the deans, Dr. Robert Bucher of Temple, said the deans have been working toward these ends and wholeheartedly support the effort of the student committee. Their statement said: "The medical school deans have met with these students and have found that they have a number of fresh ideas for recruiting more Negro applicants. Discussions, however, have raised the same problems which have thwarted our efforts in the past . . ."

The deans said they consider this a matter of first priority for medical schools and they are confident that the schools "can surmount the problems."

The task forces will seek help of students, faculty and other leaders in recruiting interested applicants, finding new sources of financial assistance and the development of new methods to help those students who are admitted to graduate.

The deans added: "the task forces will be asked to do these things quickly and to make recommendations . . . for making prompt and substantial increases in the number of Negroes and disadvantaged students in our medical schools."

An Invitation To Meet

At its meeting the 1968 House of Delegates considered the following portion of the annual report of David S. Masland, M.D., Trustee and Councillor of the Fifth Councillor District:

Because of the close location (of the Cumberland County Medical Society) the society held its meeting in May at the Headquarters Building of the Pennsylvania Medical Society. The members of the society learned first-hand from PMS staff members the functions of the State Society and took a tour of the building. This was a most informative meeting and the members felt it was quite helpful in creating better understanding and liaison between the Pennsylvania Medical Society and the county society. I would recommend that other county medical societies consider this kind of meeting or, perhaps, that they at least send a

large delegation to the society at intervals for such meetings.

The House of Delegates concurred with the intent of Dr. Masland's suggestion that county medical societies give consideration to having such meetings at the headquarters building in Lemoyne with a format similar to the meeting held by the Cumberland County Medical Society. The Board of Trustees takes this opportunity to call this recommendation to the attention of the county medical societies, realizing that those societies which are located some distance from Lemoyne will probably not be able to take advantage of this opportunity. Interested county societies are encouraged to write David H. Small, Assistant to the Executive Director, at the headquarters building in Lemoyne.

WILLIAM A. LIMBERGER, M.D.
Chairman, Board of Trustees

State Hospital Sets Service Record

Fifteen-month-old Matthew Witters, son of Anne Witters of 428 North Twelfth St., Lebanon, helped the State Hospital for Crippled Children at Elizabethtown reach an important milestone of service recently.

Matthew, who was brought by his mother to the hospital's weekly clinic for examination of the muscles of his left foot, was the 15,000th young patient to be treated at the State Health Department facility since it was opened in the spring of 1930.

He was examined by pediatric specialist Lionel C. Rose, M.D., and orthopedic specialist Alfred J. Cooke, M.D., both associated with the Health Department.

Originally, the State Hospital for Crippled Children was founded to provide treatment for children with tuberculosis of the bone and for a limited number of other conditions.

But in the more than thirty-eight years since that time, tuberculosis has become comparatively rare in children while other health problems have increased.

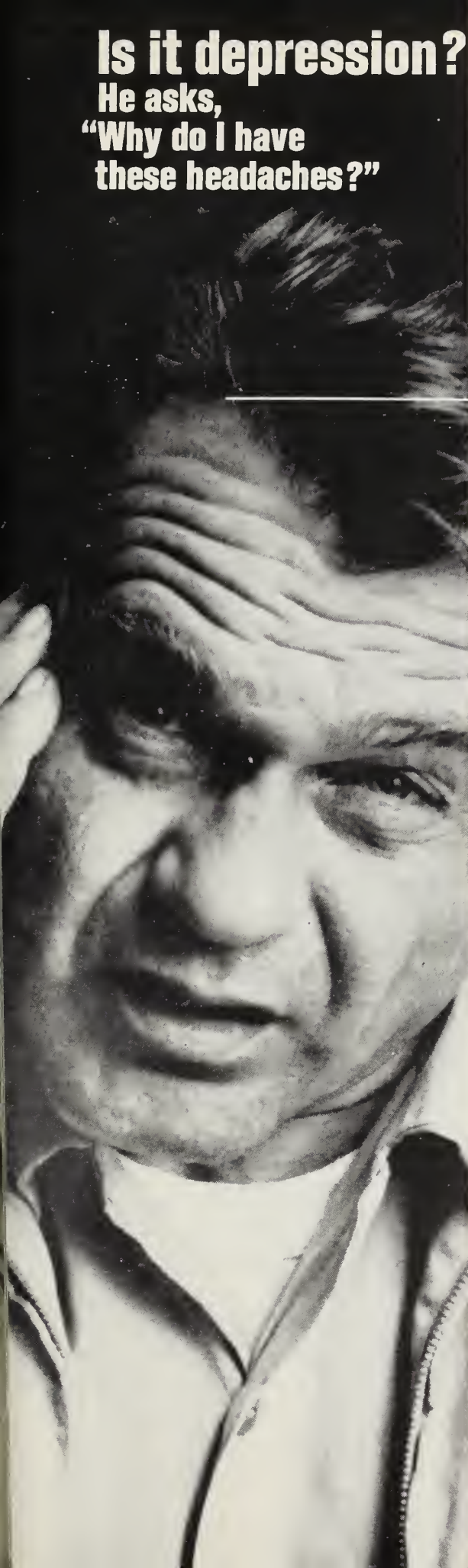
Consequently, today the hospital

provides a comprehensive setting for the diagnosis, care and rehabilitation of children with a wide variety of orthopedic and neuromuscular disabilities, or with burns, amputations or cerebral palsy. Patients from birth to twenty-one years of age are accepted from all areas of the State for diagnosis and treatment.

Both outpatient and inpatient treatment programs are available for youngsters with disabilities that are reasonably likely to respond to, or improve under, the various types of care available at the facility.

As explained by Robert W. Saunderson, Jr., M.D., medical director at the hospital, the entire goal of today's treatment program there is "restoration or improvement of function to enable the child to live a life as nearly normal as possible."

Dr. Saunderson emphasizes that "although our hospital serves the entire Commonwealth by providing special diagnostic and treatment facilities for disabled children, it is but a part of a vast team of agencies and professional people working for better health in each community in Pennsylvania."



Is it depression?
He asks,
"Why do I have
these headaches?"

**...but his other symptoms:
functional somatic complaints,
anxiety, insomnia, loss of interest,
anorexia, feelings of guilt
strongly suggest
an underlying depression.**

when the diagnosis is depression

ELAVIL[®] HCl **(AMITRIPTYLINE HCl | MSD)**

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; for intramuscular use, in 10-cc. vials containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, and methylparaben 1.5 mg. and propylparaben 0.2 mg. added as preservatives.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

 **MERCK SHARP & DOHME** Division of Merck & Co. Inc. West Point Pa 19386

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

“... In The Pursuit Of Excellence ...”



Pennsylvania drug firm—Merck Sharp & Dohme, West Point, became the nation's first recipient of the U. S. Defense Supply Agency's Industrial Zero Defects Achievement Award, presented "for creating and sustaining a most dynamic Zero Defects Program which has added stimulus to the conscientious effort of all employees in the pursuit of excellence." Participating in the presentation ceremony are (left to right): John J. Horan, executive vice president and general manager, Merck Sharp & Dohme Division; Brigadier General William M. Mantz, U. S. Army, commander, Defense Personnel Support Center, Philadelphia; Henry W. Gadsden, president, Merck & Co, Inc.; Brigadier General Ralph H. Spanjer, U. S. Marine Corps, deputy assistant director, Plans, Programs and Systems Headquarters, Defense Supply Agency; William E. Keppler, vice president, Merck Sharp & Dohme Manufacturing Division; and Colonel Gerald Johnson, U. S. Army, commander, Defense Contract Administration Services Region, Philadelphia.

Lady M. D.'s Retraining for Practice

Nine women M.D.'s, who have been out of the main stream of medicine, are now retraining at Woman's Medical College of Pennsylvania in Philadelphia, Pa. The pioneer program, the only one of its kind in the country, aims to help alleviate the growing shortage of doctors by retraining women physicians who have left medicine primarily to raise families or pursue other personal goals.

The new venture, partially funded by a \$30,000 grant from the Josiah Macy, Jr., Foundation, was originally planned by a committee under the direction of Eva Fox, M.D., WMC's professor of radiology.

The program, headed by Ethel Weinberg, M.D., a wife and mother of two children herself, offers special studies which will help return the doctors to productive medical lives.

In this pioneer project, the retrainees attend classes three full days a week for nine months. Each day

of classes, there is an hour and a half lecture-review of general medicine with emphasis on recent advances. The rest of the time is tailored to suit each retrainee's needs with ample opportunity for her to participate in out-patient and in-patient services in the area of her special interest.

The retrainees differ widely in personal and professional backgrounds. One is a Catholic nun who lives in a Philadelphia convent. Another has come half-way around the world from India. Eight of the doctors are married and have a total of twenty-six children. With one exception, the physicians range in age from thirty-one to forty-seven.

Their professional experience runs the medical gamut too. Four doctors have always been active medically. Another physician has been out of medicine for fourteen years, with the remaining doctors inactive for lesser periods of time.

Cigarette Buying Down; Lung Cancer in Women On The Increase

Over-all cigarette consumption in the United States declined in the current fiscal year, the American Cancer Society reports in "1969 Cancer Facts and Figures," issued recently.

The booklet states there are about twenty-one million Americans who have quit the habit, including 100,000 physicians, half of all physicians who ever smoked—a statistic that may be reflected in the fact that "during the first half of 1968 Americans bought some forty million fewer cigarettes each day than in 1967."

The decline—from 572.6 billion to 571.2 billion—occurred despite the tobacco industry's ever-increasing expenditure for advertising which soared to more than \$235 million in the current year. In its new report, the society explains that the decline "is generally and widely attributed to the effects of intensified anti-smoking efforts."

In spite of this encouraging trend, the society estimates that lung cancer will kill approximately 59,000 Americans in 1969.

"We are doubly concerned because the historically lower lung cancer death rate for women is beginning to show a slow, steady rise," said Roger A. Harvey, M.D., president of the society.

"This is a tragically ironic new trend," he noted, "because the very same set of 1969 'Facts' marks a continuing victory over what used to be the leading cancer killer among women—uterine cancer."

More than slashed in half in the past twenty-five years, the number of uterine cancer deaths will drop again next year, although incidence of the disease will remain constant at 44,000 new cases. Early detection, which keeps the incidence rate high, explains why the death rate is dropping: uterine cancer, like many forms of the disease, is most curable when discovered early.

Survival rates for many forms of cancer have gone up and it is estimated that 205,000 cancer patients will be cured next year. There are one and one half million people alive in the United States today who have been cured of cancer.

n the complex picture
of moderate to severe anxiety...



here is a **new** reason
for prescribing **Mellaril**
(Thioridazine HCl)

Effectiveness in mixed anxiety-depression

ng recognized for its usefulness in the
atment of moderate to severe anxiety,
ellaril is now also known to be effective
inst mixed anxiety-depression.

ten the symptoms of anxiety states are
icult to sort out—even with the most careful
bing. The patient may manifest symptoms of
tation, restlessness, insomnia, somatic
plaints. But what of the depression that may
mixed in the total picture? It is reassuring
know that Mellaril may be prescribed—with
ong possibilities of success—when there is
xiety alone or a mixture of anxiety
r depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

**for moderate to severe anxiety
and mixed anxiety-depression**



SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J.

68-169

Q. How much does the **anticostive* hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
 Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60



anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?



LEDERLE LABORATORIES
 A Division of American Cyanamid Company
 Pearl River, New York 10965

TAO[®] (triacetyloleandomycin)

Brief Summary

INDICATIONS: Include staphylococci, streptococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires reevaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.



J. B. ROERIG DIVISION
 CHAS. PFIZER & CO., INC.
 235 EAST 42nd STREET
 NEW YORK, N.Y. 10017

In vitro
susceptibility results
with **TAO[®]** (triacetyl-
 oleandomycin)

in *Staphylococcus aureus* cultures,
as shown in
studies of
antibiotics.

SUSCEPTIBILITY RESULTS^{1,2,3}
Staphylococcus aureus

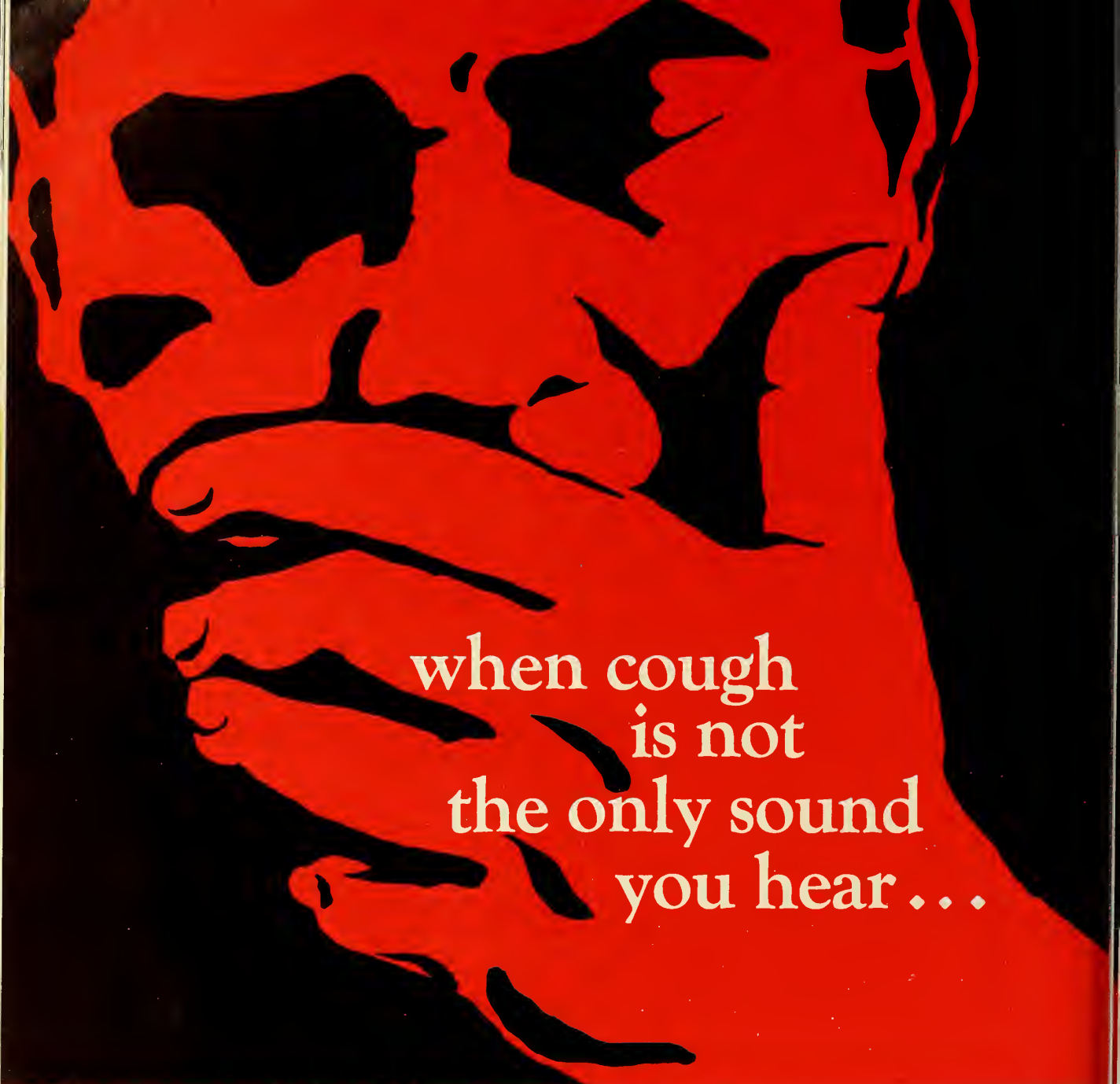
# OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1 Fowler, J. Ralph et al. Clinical Medicine 70 547 (Mar.)
 1963 2 Isenberg, Henry D. Health Laboratory Science 1 185-256 (July,
 Aug. 1964) 3 Isenberg, Henry D. Health Laboratory Science 2 163-173
 (July) 1965

TAO[®] (triacetyl-
 oleandomycin)

is a macrolide antibiotic, for use only in
the treatment of acute severe
infections where adequate
sensitivity testing has
demonstrated susceptibility
to this antibiotic and resistance
to other less toxic agents.





when cough
is not
the only sound
you hear...

OMNI-TUSS[®] b.i.d.

... **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaicol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.

Children (6-12 years): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strassenburgh

Strassenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.



close-up/MD's

A physician who helped draft and direct the federal government's regional medical programs (heart disease, cancer and stroke) has been named chairman and professor of community medicine at the University of Pennsylvania School of Medicine. The ap-



DR. KISSICK

pointment of **William L. Kissick, M.D.**, 36, was announced by **Alfred A. Gellhorn, M.D.**, dean of the medical school. At Pennsylvania, Dr. Kissick will develop new programs in community medicine designed to prepare today's medical students for the practice of medicine in future decades. Courses will stress relevant social, economic and psychologic aspects of medical care to give students a profile of the total needs of the patient and his family within the framework of his community. A native of Detroit, Mich., Dr. Kissick received his B.A. in behavioral and biological sciences from Yale in 1953 and his M.D. there in 1957. He interned at the Yale-New Haven Medical Center (1957-58). In 1959, Dr. Kissick earned a master of public health degree in administration and in 1961 a doctorate of public health in epidemiology, both from Yale University.

Leroy E. Burney, M.D., vice president for health sciences at Temple University, has been elected chairman of a medical-pharmaceutical committee studying areas of public policy on drugs use and treatment. The former U. S. surgeon general was elected to head the Greater Philadelphia Committee for Medical and Pharmaceutical Sciences. He succeeds **Thomas M. Durant, M.D.**, chairman of the department of medicine at Albert Einstein Medical Center, North, who resigned. Elected vice chairman was **Marcus Reidenberg, M.D.**, assistant professor of pharmacology at Temple University School of Medicine.

Jan Lieben, M.D., formerly director of the division of occupational health, Pennsylvania Department of Health, has joined the central medical staff of the American Viscose Division, FMC Corporation, according to an announcement by **J. A. Calhoun, M.D.**, division medical director. Dr. Lieben will be located in the Philadelphia office and will assist Dr. Calhoun with various divisional medical affairs and presently act as an associate medical director.

Melvin F. Strockbine, M.D., has been named to head the newly-established section of radiotherapy at the Harrisburg Hospital. He will also serve in the section of nuclear medicine as an associate physician. Dr. Strockbine returned to the hospital after serving two years of residency in radiation therapy at the Geisinger Medical Center, Danville, followed by two years as a National Cancer Institute fellow in radiotherapy at the University of Texas M.D. Anderson Hospital and Tumor Institute at Houston.

John V. McCormick, M.D., a resident in internal medicine at The Geisinger Medical Center since 1965, has been appointed to the permanent staff in the department of medicine at the medical center. Dr. McCormick received his medical degree from Tufts Medical School, Boston, Mass., and served his internship at Mountainside Hospital, Montclair, N. J. For two years previous to his residency at Geisinger Medical Center, he served with the armed forces.



DR. MCCORMICK

Stanley F. Druckenmiller, M.D., Lansford, was honored recently as he celebrated his 84th birthday at a surprise party arranged by doctors and nurses of Coaldale State Hospital. Dr. Druckenmiller has practiced medicine for 57 years.

John E. Carroll, Jr., M.D., has been appointed an assistant in the department of orthopaedic surgery at The Geisinger Medical Center. Dr. Carroll has been in practice in Dayton, Ohio for the past three years and held courtesy staff appointments there with the Kettering



DR. CARROLL

Hospital, Miami Valley Hospital and St. Elizabeth Hospital. He received his premedical education at Loyola College, Baltimore, Md., and his medical degree from the University of Maryland. Following his internship at Bon Secours Hospital, Baltimore, he held residencies at Bon Secours and New York Orthopaedic Hospitals.

Leo Madow, M.D., professor and chairman of the department of psychiatry and neurology at Woman's Medical College, represented the American Psychiatric Association at the International Congress for the Mentally Handicapped in Jerusalem, October 20-27. The Congress will consider "The Mentally Retarded—From Charity to Rights."

William H. Magill, M.D., Danville, was one of the early physicians in that area, arriving, according to Brower's History, in 1817, and establishing a practice which filled a great need among early settlers for medical services. He took an active part in civic and religious affairs in the community. He and his wife, daughter of General Daniel Montgomery, built a house on Market Street in Danville.

John T. McGeehan, M.D., St. Mary's, recently had a paper published in the *Journal of the American Medical Association*. His subject was a new method of determining the extent of heart injury due to coronary thrombosis by injection of a radioactive substance.

A. E. Chadwick, M.D., Beaver Falls, was awarded the PMS "Voice of Med-

close-up/MD's

icine" plaque at a dinner meeting of the Beaver County Medical Society recently. William J. Kelly, M.D., Pittsburgh, PMS trustee and councilor of the Tenth District, presented the award.

Harry Williams, M.D., Elkland, was named president of the Pennsylvania Coroners Association at its annual convention held recently in Erie. Dr. Williams has been Tioga County Coroner for 26 years.

The Geisinger Medical Center has announced the appointment of



DR. CADMAN

Thomas E. Cadman, M.D., as a specialist in pediatric neurology. He has a particular interest in child neurology and will practice in this field as well as in general pediatrics. He is a native of western Pennsylvania and received his medical degree from the University of Pittsburgh School of Medicine. Following his internship at McKeesport Hospital, and his residency at Akron Children's Hospital, Akron, O., he was in private practice in pediatrics at McKeesport for five years. Since 1965, he has been a fellow in pediatric neurology at The Children's Hospital of Philadelphia.

Aurora Javier, M.D., has been named the first "Psychiatric Resident of the Year" at Philadelphia State Hospital, Byberry. **Daniel Blain, M.D.**, hospital director, presented a two-volume set of Dr. William Menninger's "A Psychiatrist Looks at a Troubled



DR. JAVIER

World," donated by **Esther Smolens, M.D.**, to Dr. Javier. The award is to be a yearly event.

Mayer A. Green, M.D., Pittsburgh, participated in the Tenth International Congress of Chest Physicians held recently in Washington, D. C. He served as secretary to the International Committee on Allergy and took part in a fireside conference on bronchial asthma.

Garfield G. Duncan, M.D., Philadelphia, participated in a *Modern Medicine* "Forum" in the October 7 issue of the magazine, along with **Ernst J. Drenick, M.D.**, Los Angeles, Calif., **Seymour K. Fineberg, M.D.**, New York City, and **Charlotte M. Young, Ph.D.**, Ithaca, N. Y. Subject of the discussion was, "How Can the Physician Best Achieve Long-range Success in Treating the Severely Obese Patient." Dr. Duncan, whose specialty is internal medicine, is on the faculty of the University of Pennsylvania School of Medicine.



DR. DUNCAN

Samuel B. Hadden, M.D., Philadelphia, addressed the Fourth International Congress of Group Psychotherapy in Vienna recently. His topic was, "Rehabilitation of the Sexual Delinquent with Special Reference to the Homosexually Afflicted."

Calvin A. Colarusso, M.D., Philadelphia, has been named director of the newly-created Community Mental Health Center at Albert Einstein Medical Center. Dr. Colarusso, an assistant physician in the department of psychiatry and director of the AEMC child psychiatry



DR. COLARUSSO

outpatient clinic, has the responsibility for the Einstein mental health program that will serve some 195,000 North Philadelphia residents.

Frank H. Gardner, M.D., Philadelphia, has received a contract extension and \$37,000 in funds for studies to determine the effectiveness and safety of adenine and adenine-treated blood products for clinical use from the National Blood Resource Program. Dr. Gardner is associated with Presbyterian Hospital of the University of Pennsylvania.

Alexander M. Minno, M.D., Pittsburgh, is chairman of the pharmaceutical industry committee of the council on medical services of the American Society of Internal Medicine.

Thomas Leamon, M.D., chairman of the department of family and community medicine, Hershey Medical Center, has been named to the Pennsylvania Steering Committee for Continuing Education and Psychiatry, an agency operating under grants sponsored by the Pennsylvania Academy of General Practice and members of other appropriate agencies.

Morley R. Kare, M.D., Philadelphia, has been named director of the recently organized



DR. KARE

Monell Chemical Senses Center at the University of Pennsylvania, and an 18-member national advisory council has been appointed. **Luther L. Terry, M.D.**, the university's vice president for medical affairs and chairman of the Monell Center's national advisory council, announced the appointment.

Walter R. Seip, M.D., Pittsburgh, and **John F. Hartman, M.D.**, Erie, were re-elected chairman and vice-chairman respectively of the State Board of Medical Education and Licensure at a recent meeting.

Theodore G. Duncan, M.D., Philadelphia, spoke at the Thirteenth Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, W. Va. Oct. 26. His topic was, "Office Management of Diabetes." Dr. Duncan is associate in medicine at the University of Pennsylvania School of Medicine.



DR. DUNCAN

Alfred Bongiovanni, M.D., Philadelphia has been named recipient of the 1968 Mendell Medal awarded annually by Villanova University. Dr. Bongiovanni, physician-in-chief of Philadelphia's Children's Hospital, spoke at ceremonies during which the medal, which is conferred periodically for "distinguished service in the advancement of science," was awarded to him for his work on gland development and growth problems in children.

Peter J. Cera, Jr., M.D., Riverside, who has just completed two years military service in the pathology department of the U. S. Naval Hospital at St. Albans, N. Y., has been appointed an associate member of the pathology department of The Geisinger Medical Center,

Danville.

Albrecht W. Schmitt, M.D., Philadelphia, participated in a symposium on the cervix uteri held recently in Hamburg, Germany. He is clinical assistant professor in the department of gynecology and obstetrics at Women's Medical College Hospital and director of the tumor registry of the hospital.

Thomas Outland, M.D., formerly of Elizabethtown and now in retirement in Florida, was honored recently at State Hospital for Crippled Children where he had served as chief of orthopedic surgery. Dr. Outland was present for the hospital's first annual children's orthopedic meeting during which a portrait of him, commissioned by alumni of Elizabethtown's orthopedic training curriculum, was presented to the hospital.

Irwin Baird, M.D., and **Charles Hill, M.D.**, Hershey, have received National Institute of Health research grants in recent weeks. Dr. Baird, associate professor of anatomy at Hershey Medical Center, received a second-year renewal for \$22,906 for a study of the inner ear. Dr. Hill, assistant professor of biological chemistry, received \$35,472 for the first year of a three-year study on the genetics and biochemistry of missense suppression.

Dean George T. Harrell, Jr., M.D., Hershey Medical Center, was discussion leader at a session on "The Federal Government and the Medical School" at the National Institutes of Health Seminar on Science and Public Policy recently at Fort Belvoir, Va.

John W. Hope, M.D., and **Harry C. Bishop, M.D.**, Philadelphia, addressed members of the American Roentgen Ray Society at the annual meeting held recently in New Orleans. Their topic was "The Diagnosis and Treatment of Bilateral Wilms' Tumors." **Mark M. Mishkin, M.D.**, and **John**

Hale, M.D., also of Philadelphia, presented a study entitled "Selected Angiography in Abdominal Emergencies at the session. Another study entitled, "Rapid Blood Flow Rates During Routine Selective Arteriography: An Application of Television Fluorodensitometry," was presented by **Norman R. Silverman, M.D.**, **J. H. Heslep, M.D.**, **R. R. Greening, M.D.**, **R. Padula, M.D.**, and **R. Curely** and **J. W. Wallace**, all of Philadelphia.

Anna M. Brady, M.D., East Falls, former chief of orthopaedics at Frankford Hospital, left recently for Vietnam with the 305th Medical Detachment. A lieutenant colonel in the army reserve, Dr. Brady is the only woman orthopaedic surgeon in the Army, and the only woman in the Army in command of a detachment of men. Her unit was the only Army Reserve unit in eastern Pennsylvania placed on active duty in the call-up last April. Dr. Brady served two years in the European theatre as an Army nurse in World War II.

Harry S. Good, M.D., Reading, physician at the Bethany Children's Home, Womelsdorf, for the past 30 years, was a special guest at a dinner held by the home's alumni association recently in honor of his thirty years of service.

Frieda Wagoner Woodruff, M.D., Bryn Mawr has been appointed college physician at Bryn Mawr college, according to an announcement by President Catharine E. McBride of the college.

K. T. Ghosh, M.D., recently of Pittsburgh and temporarily residing in Washingtonville, has been appointed as first fellow in a new fellowship program in the department of gynecology, Geisinger Medical Center. Dr. Ghosh, a native of Calcutta, will work primarily in the field of gynecologic oncology and pelvic surgery.

Quick action and immediate response to a middle-of-the-night telephone call were credited recently with saving the lives of a family of four in Waynesboro. **H. Dwight Bikle, M.D.**, of that city responded to a request to make a house call from Mrs. Robert Snurr, who, with her husband and two

children, had become ill from coal gas asphyxiation. Dr. Bikle broke into the home when there was no response to his knock, realized what had happened, led his patients to safety, and called the fire department.

Michael L. Daly, Jr., M.D., Riverside, has been appointed director of the Health Center of the Geisinger Medical Center, according to **Leonard F. Bush, M.D.**, chief of staff. The appointment was approved by the center's board of directors at a recent meeting. Dr. Daly joined the Geisinger staff in 1967 as the first associate in the newly organized department of community medicine. In this position, he has supervised patient care in the emergency room and the medical center's employee health program.

Waldo E. Nelson, M.D., editor of the Journal of Pediatrics, has been awarded the 1969 Abraham Jacobi Award of the Section on Pediatrics of the American Medical Association. Dr. Nelson has served as director of pediatric service at Temple University Hospital, as medical director of St. Christopher's Hospital for Children, and as professor of pediatrics at Temple University School of Medicine, Philadelphia.

Alexandra I. Karetas, M.D., Philadelphia, won a second prize award, in the American Society of Anesthesiologists annual Residents' Research Contest, for a paper entitled, "An Analysis of Functional CNS Deficits Induced by Local Cerebral Ischemia." Dr. Karetas received a check for \$150.

USE CHRISTMAS SEALS



**FIGHT TUBERCULOSIS
EMPHYSEMA
AIR POLLUTION**

no gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:

Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.

(Warning: May be habit forming)

To reduce hypermotility and frequency.

Homatropine Methylbromide... 0.15 mg.

A safe dose for mild spasmolysis to curb cramping and griping.

Pectin... 24. mg.

Demulcent, adsorbent. Helps form stools.

Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's dose): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID



INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976



The relief received from the first Trocinat 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinat 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society
in recent months:

ALLEGHENY COUNTY:

- JOHN E. ALLEN, M.D., 161 N. Dithridge St., Pittsburgh 15213.
WILLIAM G. BACH, M.D., 3811 O'Hara St., Pittsburgh 15213.
CHARLES P. BOWEN, M.D., 710 Broadway, McKees Rocks 15136.
JOHN A. BRUNGO, M.D., 2341 Perrysville Ave., Pittsburgh 15214.
J. JEROME BUCHMAN, M.D., 3515 Fifth Ave., Pittsburgh 15213.
ROBERT R. CARPENTER, M.D., 3530 Forbes Ave., Pittsburgh 15213.
ROBERT H. CLARK, M.D., Magee Womens Hospital, Pittsburgh 15213.
MANUEL R. DELEON, M.D., Homestead Hospital, Homestead 15120.
MARIANNE DOMOLKY, M.D., 121 University Place, Pittsburgh 15213.
CRILE DOSCHER, M.D., 403 Medical Arts Building, Pittsburgh 15213.
DON L. HENNON, M.D., 1130 Perry Highway, Pittsburgh 15237.
EDGAR O. HORGER, III, M.D., Magee Womens Hospital, Pittsburgh 15213.
LLOYD M. HORNE, M.D., 5526 Walnut St., Pittsburgh 15232.
CHARLES W. KERBER, M.D., Magee Womens Hospital, Pittsburgh 15213.
ARA PAPAZIAN, M.D., Magee Womens Hospital, Pittsburgh 15213.

BEAVER COUNTY:

- SATURNINO M. REYES, M.D., 4385 Tuscarawas Rd., Beaver 15009.

BUTLER COUNTY:

- CHARLES F. SPARGER, M.D., V. A. Hospital, Box 1565, Butler 16001.
DENNY W. WALTERS, M.D., Union National Bank, Butler 16001.

CARBON COUNTY:

- JOSE E. DAIT, M.D., 5 West Broadway, Jim Thorpe 18229.

CHESTER COUNTY:

- LEON A. SKWEIR, M.D., 781 Upper Gulph Road, Wayne 19087.

DAUPHIN COUNTY:

- FRANCIS J. GALLIA, M.D., 1501 N. Front St., Harrisburg 17102.
ANIBAL F. HEREDIA, M.D., 4212 B King George Drive, Harrisburg 17109.

MICHAEL P. HOWANITZ, M.D., 3301 Schoolhouse Lane, Harrisburg 17109.
 GEORGE W. KUNKEL, M.D., 107 Locust St., Harrisburg 17101.
 HENG F. LIM, M.D., 2200 B—Franklin Pkwy., Philadelphia 19130.
 RICHARD L. NAEYE, M.D., Hershey Medical Center, Hershey 17033.
 DAVID R. OFFORD, M.D., 500 University Dr., Hershey 17033.
 HERBERT I. SOLLER, M.D., 128 Locust St., Harrisburg 17101.
 JAMES A. YATES, M.D., Suite 716 Executive House, Harrisburg 17104.

DELAWARE COUNTY:

RUDOLPH W. BEE, M.D., 2727 West Chester Pike, Broomall 19008.

LAWRENCE COUNTY:

ANTHONY S. MASTRIAN, M.D., Room 406, Temple Bldg., New Castle 16101.

LEHIGH COUNTY:

ROBERT C. EMERY, M.D., Morrie's Acres, R.D. 1, Phillipsburg, N.J. 08865.
 HERBERT C. RADER, M.D., 315 N. West St., Allentown 18102.

MONTGOMERY COUNTY:

WARREN B. HECHT, M.D., 933 N. Charlotte St., Pottstown 19464.
 INGEBORG SCHULZE, M.D., 232 W. Montgomery Ave., Haverford, Pa. 19041.

NORTHAMPTON COUNTY:

JOSEPH L. CURRY, M.D., 79 Gordon Dr., Easton 18042.
 GEORGE M. JOSEPH, M.D., Twenty-second and Lehigh Sts., Easton 18042.
 SALOMON BENSIMHON, M.D., 35 E. Elizabeth Ave., Bethlehem 18018.
 LEE S. SERFAS, M.D., 80 Gordon Dr., Easton 18042.
 RICHARD N. STEIN, M.D., 701 N. New St., Bethlehem 18018.

PHILADELPHIA COUNTY:

LEON S. CAPLAN, M.D., 1033 Chesworth Rd., Philadelphia 19115.
 RICHARD A. DAVIS, M.D., 3400 Spruce St., Philadelphia 19104.
 JAMES A. KATOWITZ, M.D., 1930 Chestnut St., Philadelphia 19103.
 AUDREY M. R. WILSON, M.D., Parktown Place, #1912 West, 2200 Franklin Pkwy., Philadelphia 19130.
 HEINRICH BRIEGER, M.D., 2031 Locust St., Philadelphia 19103.
 SIDNEY A. BRODY, M.D., 2021 Tulpehocken St., Philadelphia 19138.
 ARTHUR F. WHEREAT, M.D., University of Pennsylvania Hospital, Philadelphia 19104.

WASHINGTON COUNTY:

JOHN S. ADLER, M.D., 829 Jefferson Ave., Washington 15301.

DECEMBER, 1968

Tuberculosis? Influenza?
 Pneumonia? Leukemia?
 Hodgkin's Disease? Syphilis?
 Systemic Fungal Diseases?
 Chronic Chest Diseases?

or

HISTO?

(Histoplasmosis—"The Masquerader")

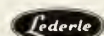


A new aid in differential diagnosis HISTOPLASMIN, TINE TEST

(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).



Ask your representative for details or write Medical Advisory Dept.,
 Lederle Laboratories, Pearl River, New York 10965. 406-8



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®. Glyceril quaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg.
 A. H. Robins Company, Richmond, Virginia 23220

A-H-ROBINS



Medicine and Mr. Nixon

From Washington, D.C., The American Medical Association reports that Richard M. Nixon will take over as President pledged to oppose national compulsory health insurance and federal control of physicians' fees. Highlights of his position on health care issues:—

Federal Role in Medicine

The role of the federal government in medicine should be supportive, never dominating. It should serve as a catalyst and supplement private efforts only as needed.

Medicare

Although the program has been plagued by financial and administrative problems, it offers good potential if wisely administered.

Medicare must provide needed services at the lowest possible cost. The program could be endangered by a continuing escalation of costs.

More effort is needed to reduce dependence on costly hospitalization through better use of extended care facilities and increased use of outpatient care. Also needed is a reexamination of reimbursement formulas and experimentation with financial incentives to assure that the program encourages efficiency at all levels.

Medicaid

I favor the basic philosophy of medicaid—that of helping medical indigents who need aid to meet medical expenses. Unfortunately, the program has fallen short of its expectations . . .

What is needed is a careful reassessment of medicaid, especially at the local level, with full professional guidance, and emphasis on advice from physicians. There also is a need for simplification of literature and application forms.

National Compulsory Health Insurance

I oppose a national compulsory health insurance program because I do not want to lower the quality of medical care in the United States. Also, new health programs should be geared only to persons in need . . .

I want to see that every individual who needs medical care is able to get it. But I want it to be good medical care. That's why I want to keep the doctors free from government control as much as possible and oppose extension to a national compulsory health insurance program for everyone.

Compulsory Areawide Health Planning

I oppose compulsory areawide health planning. We can't assure communities better health planning just by making such groups compulsory. Areawide planning should be left to state and local determination.

Federal Control of Physicians' Fees

I oppose federal control of physicians' fees. Our system is an open, competitive market, assuring an individual the prerogative of setting a value on the services he performs. I would be as opposed to infringing on this right by regulation of physicians' fees as I would be to regulating fees charged by the members of any other profession.

Department of Health

As president, I intend to establish a commission on government reorganization to study thoroughly ways of increasing efficiency in government organization as well as making it more responsive to the people.

Mental Health

We must develop new methods of treating the mentally ill . . .

Tax Deductions for the Aged

The 100 percent income tax deduction for non-reimbursable drug and medical expenses of those over 65 should be restored.

Preventive Medicine

Preventive medicine is, in my judgment, both an opportunity and a major challenge to medicine.

Automated mass screening programs would seem to have great possibilities even though they are generally still in their infancy and therefore cannot yet be gauged concerning their effectiveness in preventing chronic illness and reducing deaths. Information about these programs is still inadequate to warrant a broad federal program.

Hill-Burton Act

As demand for hospital facilities increases, additional funds under the Hill-Burton Act for construction and modernization of such facilities will be required to supplement state and local efforts.

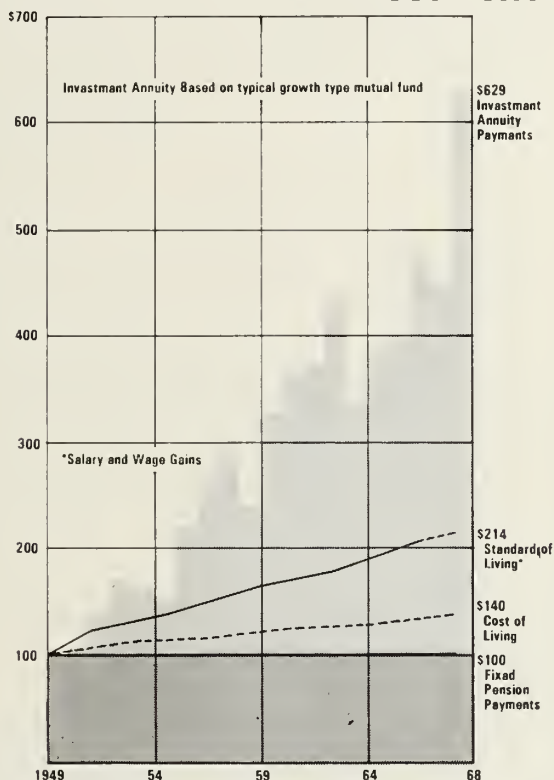
To assure the most efficient use and distribution of Hill-Burton funds, a proposal for bloc grants in this area should be considered.

Abortion Laws

Nothing should be done on the federal level. The abortion laws should be considered by each state, and should be acted upon by each state, depending upon the opinion in that state . . . I do not think that a nationally-imposed law would be one which would be accepted in many parts of the country, and only when a state—a majority of people of the state—reach a conclusion that they want that kind of legislation, as they did in Colorado and as they may in the state of New York, should such a law be passed or considered.



With an Investment Annuity, you can s - t - r - e - t - c - h the benefits of your tax-favored retirement plan by your personal control in the selection of growth-oriented investments. *Educators and Employees of hospitals, churches, charities and other tax-exempt 501 (c)(3) organizations: Does your tax-deferred annuity provide the flexibility and other attributes of the new Investment Annuity?*



This chart is an historical illustration of what the Investment Annuity retirement income benefits would have been if they had started at \$100 per month in 1949, if the retiree's account had been invested in a typical growth-type mutual fund. The chart reflects the increasing market over the past 20 years; it is not to be construed as a forecast for the future.

1. You or your chosen Investment Advisor may select the investments within a tax-sheltered annuity fund Account held by a custodian.
2. Investment changes within your personal Account may be made freely, without incurring tax on income, or on short-term or long-term gains.
3. Benefits vary each year to reflect the investment performance of your personal Account.
4. Benefits may be guaranteed to last for life or on a joint and survivor basis, with payments guaranteed for 5, 10, or 15 years in any event.
5. Benefits for survivors can be increased with FIAC's optional low-cost one-year term insurance to provide growth-oriented, tax-favored lifetime income for your beneficiary.

If you would like to receive a free, 12-page detailed booklet and enrollment forms, mail the coupon today.



FIRST INVESTMENT ANNUITY COMPANY OF AMERICA
1500 Chestnut Street, Philadelphia, Pennsylvania 19102

Name _____ (PM)

Address _____

City _____ State _____ Zip _____

Title or Occupation _____

Employer's Name _____



The Poor And You

OEO Neighborhood Health Centers

Can an effective partnership be forged between organized medicine and private and governmental agencies interested in the improvement of the delivery system of medical care? This is the question posed by Dr. Mat Marshall in this issue of PENNSYLVANIA MEDICINE.

There appears to be a growing opinion that the fee for services and traditional patient physician relationships are

outmoded if the medical needs of the urban poor and rural areas are to be met.

Dr. Marshall provides "food for thought" in his article. No physician can be divorced from his community if he is to exercise any influence on future change.

DAVID A. SMITH, M.D.
Associate Medical Editor

"Thy Staff"

The State Medical Society runs so smoothly for such long stretches of time that many physicians are infrequently conscious of its existence. This is certainly a great saving of time and effort and a real tribute to the officers, committees, and staff. But it also presents an occasional disadvantage.

For example, in the wake of the recent legislative debacle in Pennsylvania which authorized the payment of chiropractors by Medicaid (Title XIX) many physicians were outraged at the failure of their state society to prevent the passage of the legislation which permits the tragic blunder.

These members were, in varying degrees, confounded when shown how often and how hard their state organization had tried to secure individual or county society action to defeat this measure. Some participation by the member physician is essential—one cannot rely entirely on his state office.

To return to our statement in praise of the organization and workings of the state medical society, let us examine a main source of its efficiency and accomplishments—the men who make up the staff. Their skills and efforts are most clearly valuable in freeing the doctor from innumerable routine duties. Their skilled services make it possible for the many physicians in the state organization to carry out their own functions effectively. Without the sustained and expert attention of our staff personnel, the majority of our scheduled tasks and functions might be omitted or long delayed. Without the guidance of these staff specialists most of the physicians' work would be far more difficult, far less effective, and very often abandoned.

One major qualification which makes the staff so valuable should not surprise the doctor—its professionalism. Members of the staff are carrying out programs and projects for which they are prepared by training and experience. They are full-time people in two senses. First, this is their

only occupation; they are not turning from some other devotion to give a few moments to the problems of our medical organization. Secondly, they are full-time in continuity; they continue their work through more than a term in office and from year to year. Moreover, their jobs are not only full-time, but also their primary occupations, calling out their first and best efforts.

To their work they bring one other qualification of the professional. They are not likely to be swayed by the emotional involvement of the membership, but can bring to their tasks the cool detachment which professional skills confer. The continuing productiveness of these qualities is well seen in our veteran staff as one of our greatest assets—their experience. There is no substitute for years of work in the society's office.

When it is time to praise them, the virtues named above are less often cited than the more popular virtues of concern and dedication. This cannot be faulted. It is a wonderful thing to realize the degree of concern which our staff shows in attending to our affairs. That worn-out word "dedication" does apply to them. They take their work and our problems home. Everybody knows that the five-day work week is not for the man who serves one of our committees. The doctor can find no better time for his meeting than Sunday, unless it be Saturday night. I have often heard physicians express wonder at such dedication. Let us be grateful and admit that it is not easy to explain.

Another benefit from the work of the men and women at the state office arises from their ability to interrelate with similar workers. This is most readily visible when a staff executive assists in our deliberations by telling of actions by other components of organized medicine. It is, however, more importantly realized in the complex but fruitful interactions between the staffs of medical societies and those of the many non-medical associations and groups

with whom we must work. As medicine becomes more active in the devious progress of our civilization, this becomes more obvious and more valuable.

I say that there is a need for every physician to understand and appreciate the function and procedures of his state medical society just as he needs to realize its importance. As a part of this comprehension he must see the

value to him of the work of the executive staff and of the staff assistants. These people are, as I have here indicated, a special breed, and richly deserve our commendation and appreciation. Our own contribution of skills, time and effort is indispensable but we must understand that the staff, by means of expertise, concern and dedication, multiply its effect to a high degree.

CBL

Guest Editorial

Man is Not Alone

To anyone whose work is "with people" it is axiomatic that man is never alone. Man cannot be understood except in the context of family, group, clan, people and a living tradition. This sense of interdependence comes out most clearly in times of crisis and especially in times of illness. Then man reaches out for physical support and spiritual sustenance to those who are his "kin." He must have the reassurance that someone cares; that he is needed and wanted. That is his incentive to recover.

More than twenty centuries ago, Judaism discovered this truth, that man is not alone. It made of Judaism a social religion, deeply concerned with human interrelationships. Visiting the sick, concern for daily observances of prayer, dietary laws, Sabbaths, holidays—these became sacred obligations, commandments emanating from God, Mitzvot.

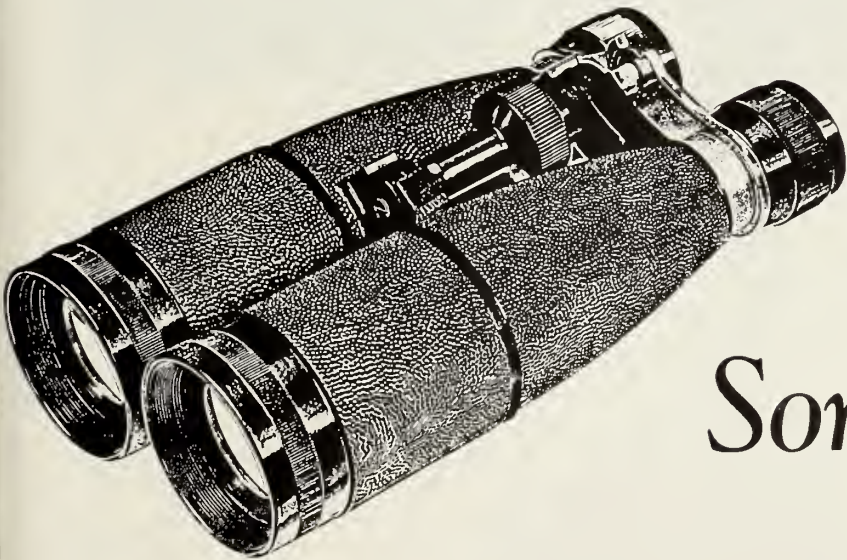
The problem of concern becomes critical in terminal

illnesses. Now it is not alone the patient who needs care. It is also his family who hover over him. Here minister and physician must work closely together to keep the family on an even keel so that all concerned will face the ordeal of death with dignity and courage.

The primary function of minister and physician is to lift the morale of both the patient and the family. The patient should be told only what will fortify him. The family can be told "the truth" only if they can cope with it.

In dealing with the sick, and particularly the dying, Judaism enjoins on those in charge a genuine human concern. We never treat a body or a disease—we always deal with a person.

RABBI ELIAS CHARRY
Reprinted from *Philadelphia Medicine*



Looking for Something?

Try PENNSYLVANIA MEDICAL SOCIETY
PHYSICIAN PLACEMENT SERVICE

It's almost as if you were there to give an injection of penicillin



dependable oral penicillin therapy **V-Cillin K[®], Pediatric** Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin[®] (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K[®] (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K[®] (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful).

[042567A]

800197

Additional information available
to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206





Blowout Fractures of the Orbit

by LOWELL R. WILDER, M.D.
Pittsburgh

Blowout fractures of the orbit are common occurrences but the diagnosis is frequently overlooked. When evaluating any facial injury, whether it be minor or extensive, this problem should be kept in mind and looked for carefully. Although the clinical picture was first described in 1889, the concept of the blowout fracture did not evolve until about 1940. Cadaver experimentation has demonstrated that a sudden force applied to the orbit increases the intraorbital pressure as in an hydraulic system. This pressure causes the bony orbit to give way at its weakest point, the orbital floor. The orbital contents then herniate through this fracture into the maxillary sinus. The common causes of blowout fractures are automobile accidents, fist fights, and athletic injuries. The size of the injury-producing object is usually that of a baseball. Smaller objects, such as a golf ball, rupture the globe and larger objects tend to fracture other facial bones.

Signs and Symptoms

The most common presenting symptom is diplopia, especially in upward gaze. This indicates that the inferior rectus muscle is trapped in the fracture. In children this diplopia may cause nausea and vomiting. A small object should be presented to the patient in downward, straight ahead, and upward gaze to determine if he sees one or two objects.

The most common presenting sign is anesthesia below the eye. The maxillary division of the fifth cranial nerve passes through the infraorbital groove. This groove is the weakest area of the orbital floor and is usually involved in the fracture line. This sign may be tested by pricking the skin below the eye with a pin.

Although edema and ecchymosis of the lids may camouflage this sign,

enophthalmus is usually present. Generally the lids are markedly edematous and difficulty may be encountered in separating them. Blood in the maxillary sinus may lead to a unilateral epistaxis.

Radiography

X-rays are an important adjunct in establishing the diagnosis. There are many good techniques in demonstrating this fracture. The Water's nose-chin position and laminograms are very reliable in outlining the orbital floor and surrounding structures. Although linear fractures are difficult to demonstrate, a blowout into the sinus is usually quite evident. The antrum is frequently cloudy due to blood.

Treatment

The treatment is surgical and must be initiated before seven days in order

to prevent fibrosis of the inferior rectus muscle and orbital fat at the fracture site. By using an orbital approach, the fracture site can be directly observed. The primary advantage of this approach is that the incarcerated material can be removed from the fracture under direct observation. A thin plate consisting of a synthetic material is placed over the fracture and left in place permanently.

Conclusions

When evaluating any facial trauma, the possibility of a blowout fracture of the orbit must be kept in mind. The most important findings are diplopia, anesthesia below the eye, and enophthalmus. The treatment is surgical and should be initiated by the seventh day.

REFERENCES

1. Patterson, R. W., and Depue, R. V., Jr.: Blowout fracture of the orbit, *Am. J. Ophth.* 53: 841, 1962.
2. Converse, J. M., and Smith, B.: Reconstruction of the floor of the orbit by bone grafts, *Arch. Ophth.* 44: 1, 1950.
3. Converse, J. M., and Smith, B.: Blowout fracture of the floor of the orbit, *Trans. Am. Acad. Ophth.* 64: 767, 1960.
4. Kaye, B. L.: Orbital floor repair with antral wall bone grafts, *Plast. Reconstruct. Surg.* 37: 62, 1966.
5. Durgmou, R. O., and Natirg, P.: *Surgery of Facial Fractures*. Philadelphia, Souders, 1961, p. 230.
6. Quereau, J. V. D., and Souders, B. S.: Teflon implant to elevate the eye in depressed fracture of the orbit, *Am. J. Ophth.* 55: 685, 1956.
7. Anthony, D. H.: Diagnosis and surgical treatment of fractures of the orbit, *Trans. Am. Acad. Ophth.* 56: 580, 1952.
8. Converse, J. M., and Smith, B.: Blowout fracture of the floor of the orbit, *Surg. Ophth.* 7: 304, 1962.
9. Smith, B., and Regan, W.: Blowout fracture of the orbit, *Am. J. Ophth.* 44: 733, 1957.
10. Goren, S. B., Shauss, R. B., and Osborn, D. B.: Blowout fracture of the orbital floor, *Am. J. Ophth.* 61: 893, 1966.
11. Erdbrink, W. L.: Blowout fracture of the orbit, *Am. J. Ophth.* 49: 1037, 1960.
12. Duke-Elder: *Textbook of Ophthalmology*. St. Louis, Mosby, 1954, Vol. VI, p. 5917.



■ Dr. Wilder is chief resident in the department of ophthalmology at Eye and Ear Hospital, University of Pittsburgh School of Medicine.



Total body thermography examination is accomplished in a few minutes. The technician checks the newspaper facsimile paper image produced by Smith-Pyrosan.

Thermography As An Investigative Method

by CORINNE B. FARRELL, M.D.
CARL MANSFIELD, M.D.
JOHN D. WALLACE
Philadelphia

Jefferson Medical Center has used thermography for the past four years as an investigative tool in the diagnosis and follow-up care of selected patients with a variety of diseases. Our experiences include thermography in the study of patients with carcinoma of the breast,^{1, 2, 3} vertebral disc disease,⁴ osteosarcoma,⁵ and metastatic disease of known and unknown primaries. Our use of thermography has also been applied in patients with other disease.

Non-medically trained personnel obtain the scans by using the Pyrosan,* a high speed infrared scanning device that performs 40,000 separate temperature measurements of a 24 X 24 inch area in thirty seconds. The range of temperature is 6 degrees centigrade and the sensitivity is 0.3 degrees. The resultant output of the scanner is a picture of temperature distribution displayed on newspaper facsimile paper. The polarity of the temperature read-out has been selected so that the warmer areas are recorded darker than the colder areas.⁵

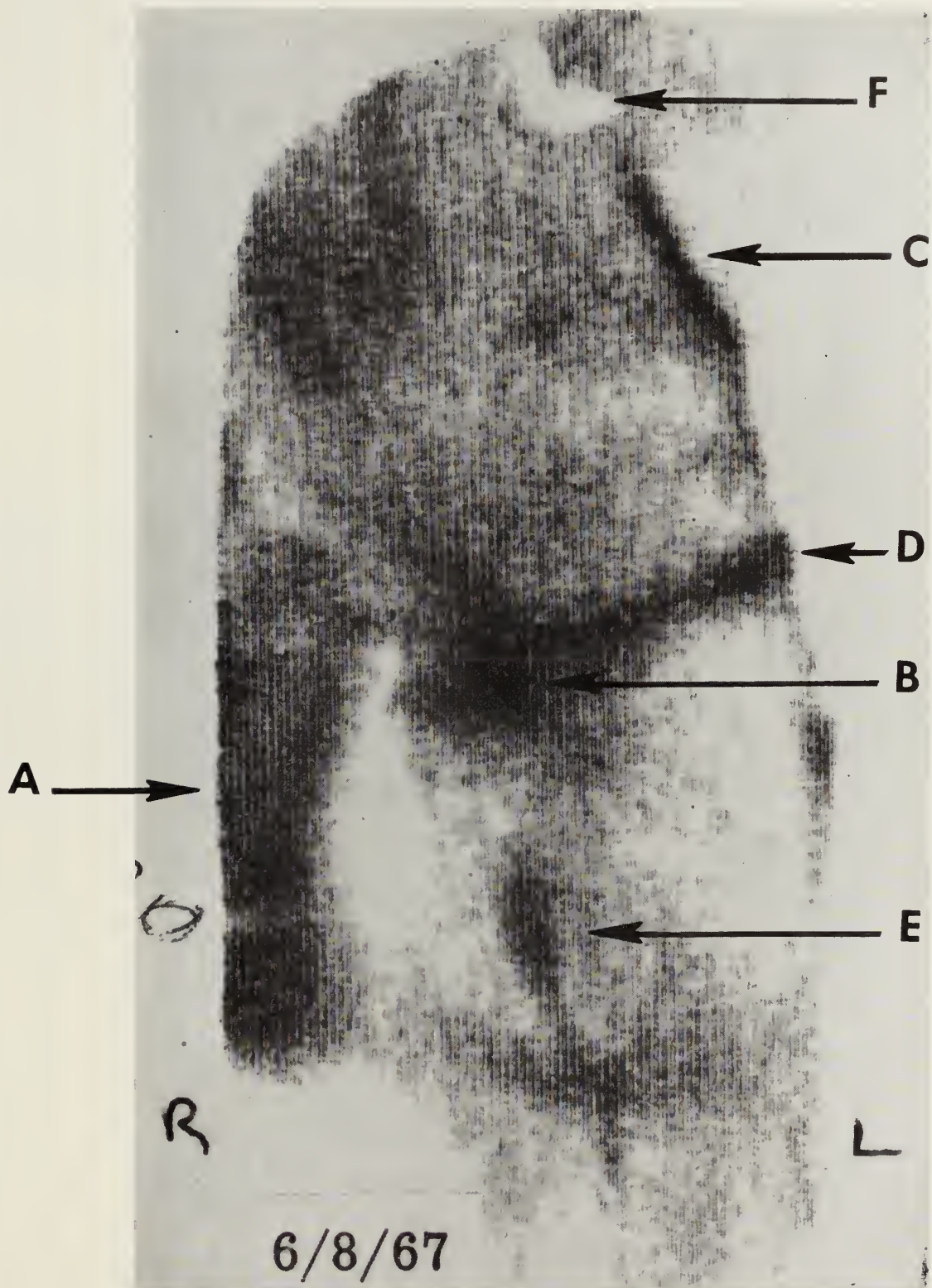
The patient to be scanned is exposed for eight minutes in the examining room where the temperature has been stabilized to 68 degrees Fahrenheit. This skin stabilization is done to eliminate areas of increased temperature due to clothing and to enhance the temperature contrast of the skin. The patient is scanned in the anterior, posterior and both lateral positions with multiple scans at three temperature sensitivity levels.

Our past experience in thermography has been the basis of examination interpretation. The basic tenets of abnormality include:

1. Asymmetry of right and left body heat distribution.
2. Presence of local or diffuse heat distribution patterns.
3. Presence of vessel pattern associated with heat distribution.
4. Absence of normal heat distribution in local or diffuse areas of the body.

The fast scanning procedure allows examination of both the right and left side of the body nearly simultaneously. Heat patterns not thought to be normal or due to artefact must be studied closely in multiple views with different sensitivity levels. Knowledge of normal body heat pattern is essential, for example, areas such as the tip of the nose, the pinna of the ears, the orbit

* Smith Industries Ltd., London, England.



Left lateral oblique body thermogram demonstrates several areas of increased temperature: A, increased temperature of hand and arm due to previous position under patient: B, a diffuse irregular shaped area of increased temperature of the lumbar spine thought to be metastatic disease: C, D and E, are increased temperature due to apposition of body surfaces of arm, chest wall, abdominal fat fold and gluteal fold: F, is the lead body side marked artefact.

of the eyes, the testicular region and patella are cool. Areas covered with abundant hair, such as the head, pubic region and axilla are also cool.

Local regions of the body may have areas of increased metabolism and can produce a small usually discrete area of elevated temperature. These can be multiple and are referred to as the "polka dot" pattern.

Artefacts are abnormal heat patterns commonly caused by insufficient patient cooling-room stabilization. Other causes include patient resting hands on knee, thighs or hips and the arms folded across the chest. The presence of jewelry, clothes, casts, bandages and the metal marker used to signify the body side can give abnormal heat patterns.

The obese patient normally exhibits areas of increased temperature at the sites of opposing skin surfaces, such as abdominal, inguinal, posterior popliteal fat folds.

Most diagnostic methods have pitfalls which await the uninitiated. The patient presenting with a large area of pathology can show a very large area of increased temperature and this can be completely missed because of its size. Selection of the polarity together with the experience of reading large numbers of scans has considerably lessened this shortcoming. Advanced stages of disease have on occasion failed to demonstrate areas of increased temperature. The mechanism is unknown and can lead to false negative interpretation. Super-imposed anatomical structures must be considered when abnormal heat patterns are observed. Multiple views may help to eliminate the structures not involved.

Functioning ovarian tissue has been recorded as an area of increased temperature in the low pelvis and can be misinterpreted as a possible tumor or infection. Menstrual history will often help to eliminate this as the etiology of the temperature increase in the pelvis.

Observation of the normal thermographic findings and their correlation to the examined anatomy is necessary. Over reading thermographic scans occurs, but with reading experience and correlation of clinical history and physical findings this difficulty is not common.

As an example of the use of thermography in our department, one case is presented. A sixty-four year old female underwent a radical mastectomy for infiltrating ductal carcinoma of the left breast. Seven months post-

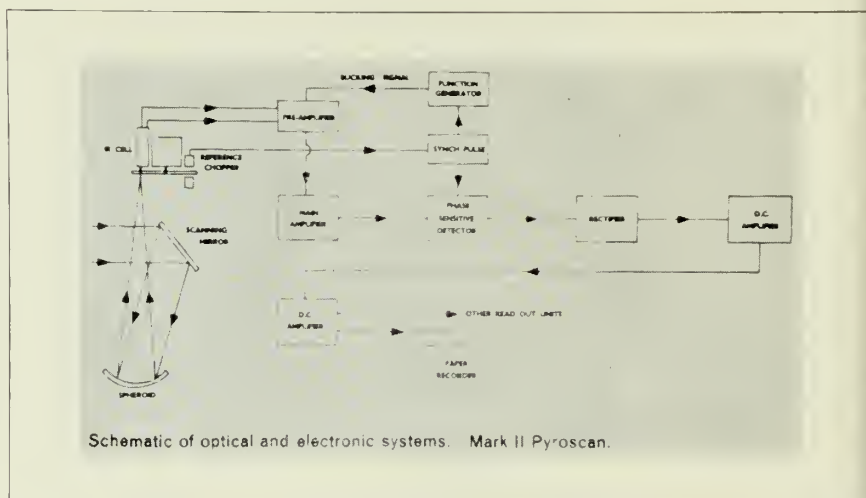
operatively she complained of severe low back pain. Thermographic examination was interpreted as probable metastatic disease of the L-4, L-5 lumbar spine (Fig. 1). Roentgenogram and mylogram of the area confirmed the presence of metastatic lesions of L-4, L-5 lumbar spine.

Conclusion

Thermography has been helpful as an investigative tool in the diagnosis and follow-up assessment of patients with a variety of diseases. Continued and expanded use of this examination is expected.

REFERENCES

1. Wallace, J. D.; Goldman, Arnold; Dodd, G. D.; Stauffer, V. and Taylor, J.: Rapid scanning thermography in suspect breast evaluation, *Radiology* 84: 132: 1965.



The diagram of the optical and electronic systems of the Smith-Pyroscon. (Smiths Industries Limited. London, England).

2. Wallace, J. D. and Dodd, G. D.: Thermography in the diagnosis of breast cancer, In Press, *Radiology*, 1967.
3. Freundlich, I. M.; Wallace, J. D. and Dodd, G. D.: Thermography and the venous diameter ratio in the detection of the non-palpable breast carcinoma, In Press, *Amer. J. Roent.*, 1967.
4. Farrell, C.; Wallace, J. D.; Edeiken, J.: Thermography in osteosarcoma In Press, *Radiology*, 1968.
5. Edeiken, J.; Wallace, J. D.; Curley, S.: Thermography in herniated lumbar disc disease In Press, *Amer. J. Roent.*, 1968.
6. Lawson, R. N.; Gaston, J. P.: Temperature measurements of localized pathologic processes, *Annals of the New York Academy of Sciences* 121: 90-98: 1964.
7. Wallace, J. D.: Thermography in ischemia, *Radiologic Clinics of North America* 5: 505-513: 1967.

■ Dr. Farrell, Dr. Mansfield and Mr. Wallace are associated with the department of radiology, Jefferson Medical Center.



FIGURE I

Plastic container of rose bengal which is emptied into glass bottle with screw top. Glass rod for application of dye.



FIGURE II

Aesthesiometer for measurement of corneal sensitivity.



FIGURE III

Closeup of scale readings and nylon filament which is touched to the cornea. Setting of nylon filament at scale number 3.

Diagnosing Corneal Disease

by PETER R. LAIBSON, M.D.
Philadelphia

Diseases of the eye, originating in the cornea or conjunctiva, which cause intermittent symptoms may be difficult to detect during their quiescent stages. Minimal changes in the superficial layers of these tissues are frequently not seen when examined with the biomicroscope and rarely visible with a hand light. A variety of ophthalmic instruments and solutions for diagnosis are available, however, to aid in diagnosing these diseases.

Fluorescein sodium dye is the best known ophthalmic solution used for examining corneal and bulbar conjunctival tissues *in vivo*. This solution, obtainable in sterile paper strips, is the safest and most convenient form for ophthalmic use. *Pseudomonas* bacteria, capable of infecting the cornea, can readily proliferate in fluorescein solutions. This organism may totally destroy a cornea in just forty-eight hours. Solutions therefore, which may become contaminated with bacteria are contraindicated and disposable paper strips of fluorescein preferred.

Fluorescein dye stains portions of the cornea or conjunctiva where the epithelium is missing. These may be areas of the cornea which are ulcerated or where the epithelium has been removed by trauma or recurrent erosion. Pinpoint size dots may appear in the corneal epithelium and

stain with fluorescein following viral infections, allergic reactions or toxic changes following exposure to chemical irritants. The nonlethal police weapon "Chemical Mace" also causes a punctate keratitis which stains with fluorescein. Fluorescein dye is best seen with the blue filter of a slit lamp but it also may be visualized with a cobalt blue tip affixed to a hand light. For slit lamps which do not have a blue filter, a piece of gelatin or cobalt blue glass (Wratten C) may be used in the path of the light beam. These may be obtained from any photographic supply store. When using the fluorescein paper strip, it is best to put one drop of a sterile solution on the tip, shake off the excess fluid, and touch the conjunctival surface of the lower lid with the wetted strip. If an excess of the dye is present, washing away the extra fluorescein before observation at the slit lamp is helpful. Fluorescein fades rapidly in the cornea and also diffuses from the epithelium through the stroma into the anterior chamber; therefore it is necessary to look at the cornea immediately after placing the fluorescein dye on the eye. If this is not done the green fluorescence in superficial punctate corneal staining or corneal ulceration may diffuse into the stroma and give a nondescript type of stain. Fluorescein also diffuses into the adjacent superficial epithelium and may ob-

scure the extent of the original lesion after several minutes. This dye will stain epithelial breaks or areas where the epithelial cells are missing. In contrast, degenerated epithelial cells *in situ* or mucous strands do not stain. Another use of this staining method is to demonstrate an escape of aqueous fluid through a fistula following intraocular surgery or a perforating wound after trauma.

The dye rose bengal stains degenerated epithelial cells. This dye may be used in conjunction with fluorescein or separately. The staining, which is a dark red or red purple color, shows up very clearly in the cornea and especially well in the conjunctiva. Fluorescein dye does not stand out nearly as well in the conjunctiva. Mucous in the pre-corneal tear film or in the lower *cul-de-sac* is also stained by rose bengal. Pathologically degenerated epithelial cells *in situ* either in the cornea, or in the conjunctiva, which may occur in keratitis sicca or pemphigus, to name the two most common diseases, will be seen particularly well with rose bengal application. The solution contains 1 percent rose bengal with a preservative. If an entire drop is placed on the eye, the patient will experience anywhere from mild to severe burning and discomfort. The dye will run over the cheek and stain the periorbital skin as well. It is not necessary to

put this much solution in the eye for diagnostic purposes. A glass rod with a small round tip at one end is useful in applying rose bengal to the lower lid. The rod, which can be sterilized by heat or cold sterilizing solution is immersed in the rose bengal solution and less than a drop will collect on the tip. Rose bengal comes in a plastic dropper bottle, the contents of which can be emptied into a rubber stoppered bottle into which the glass rod is inserted (Fig. 1). The tip of the rod with the dye is then touched to the conjunctival surface of the lower lid and only a small amount of dye is delivered to the pre-corneal tear film. This drop is enough for examination and does not cause discomfort. Prior application of an anesthetic is unnecessary with this form of application. The glass rods are only a penny or two a piece and are discarded after use. Using this technique bacterial contamination from continued use of the same dropper over long periods can be prevented.

A combined solution of rose bengal and fluorescein can be made and one drop of equal amounts of these two dyes delivered to the *cul-de-sac*. The following is the concentration of material used:

1. Fluorescein sodium—50 mg.
2. Rose Bengal—50 mg.
3. Sod. Chloride—45 mg.
4. Distilled water—5 grams

Norn has written extensively on the use of this solution in Denmark, but it is not commonly employed in the United States.

Mucous frequently is found in the *cul-de-sac* and occasionally on the cornea. When differentiation must be made between the corneal filaments and mucous, a 1 per cent solution of the dye alcian blue may be used. Mucous takes a blue color with the alcian blue dye while degenerated epithelial cells do not stain in this manner. Frequently small strips of mucous on the cornea are impossible to distinguish from filaments on the cornea. Although filaments may be attached by thread-like strands to the epithelium, they are freely movable over the cornea with blinking and appear exactly as does mucous debris. Filaments in reality are rolled up sheets of epithelial cells which have been sloughed from the corneal epithelium. These sheets of epithelium will stain with rose bengal; however, the mucous strands stand out even more clearly with the alcian blue.

In distinction to the previous corneal diseases which stain with various dyes, dry spots of the cornea have recently come to the attention of ophthalmologists. Two varieties of dry spots have been recognized: *dellen*, which are found adjacent to the limbus following surgery or trauma and dry spots of the cornea, appearing anywhere over the surface, but usually not at the limbal regions. The *dellen* appears adjacent to the limbus where the conjunctiva has been slightly elevated. This may follow surgery such as operation for strabismus, a filtering procedure for glaucoma, or following a sub-conjunctival hemorrhage, either from surgery or after trauma. In all of these cases the predisposing cause is an elevation or swelling of the conjunctiva at the limbus. In the cornea, the stroma thins, creating a small excavation localized to the area immediately adjacent to the swollen limbal conjunctiva. Dye that is placed on the conjunctival surface is not seen, and an optically dye-free space visualized. *Dellen* are temporary and once the conjunctival swelling adjacent to the limbus is removed or disappears, the stroma re-hydrates and the *dellen* disappears.

Dry spots of the cornea are small areas where the pre-corneal tear film has not wet the epithelial surface of the cornea properly. This condition is usually diagnosed by slit lamp examination using fluorescein to stain the pre-corneal tear film, and the blue filter of the slit lamp for observation. The dye is applied to the cornea and the patient blinks several times and then stops blinking, keeping the eye open. Small optically clear gaps may appear in the pre-corneal tear film just as water disperses on a glass surface upon which is a thin oily layer. Actually the pre-corneal tear film, possessing a superficial oily layer from the meibomian glands, is insufficient in this area and creates the dry spot. These dry spots are usually stationary. They appear in the cornea after corneal surgery, such as cataract, or corneal transplantation. Among the non-surgical causes, dry spots may be found in recurrent corneal erosions, bullous keratopathy and following such corneal infections as epidemic keratoconjunctivitis due to adenovirus type eight and herpes simplex keratitis. In these viral diseases there is usually a disturbance of the epithelium, basement and Bowman's membrane as well as the immediate

underlying stroma. The pathogenesis of dry spot production is unknown, although it is possibly related to some pathology in either the pre-corneal tear film, particularly the inner-mucoid layer, or the very superficial layer of epithelial cells which are in contact with the mucoid layer of the pre-corneal tear film. There is no good experimental data to explain this phenomenon yet. Dry spots also appear in recurrent erosion of the cornea during the quiescent stage. In this disease as well, the relationship between the tear film mucoid layer, epithelial and basement membrane, is disturbed and dry spots show up long after the eye has become quiet. Recurrent erosion may be differentiated from viral diseases by the fact that the underlying stroma is clear whereas in herpes and epidemic keratoconjunctivitis there is stromal clouding. Contact lenses should not be applied to the cornea if these dry spots are present, as they usually are not tolerated and cause recurrent symptoms when prematurely used.

Abnormalities of the pre-corneal tear film are frequently responsible for continuing ocular discomfort, with symptoms such as burning, aching, stinging, tearing and foreign body sensation occurring intermittently. Unfortunately, the available tests to measure the pre-corneal tear film are poor at best. One can very grossly estimate the pre-corneal tear fluid by observing the inferior marginal fluid meniscus which bridges the space between the lower lid margin and the cornea. The fluid meniscus may be diminished or absent with tear film insufficiency. Unfortunately, the quantitative examination of the pre-corneal tear film is very difficult. It is impossible to collect this material for analysis since as soon as instruments or solutions are applied to the eye in order to measure this basically secreted pre-corneal tear film, there is an excess of lacrimal fluid produced from reflex stimulation of the cornea and conjunctiva. Lacrimal secretions do not normally enter into the pre-corneal tear film. The Schirmer test is the only one readily available to the physician for grossly estimating the production of tear fluid aside from the observations of dye dilution. The sterile filter paper strip which is of uniform absorptive quality and length is placed in the lower lid and allowed to remain in position for five minutes. The measurement is first made without topical anesthesia since if the test

is positive (shows a decreased wetting in five minutes) the stimulus of the strip in place will not have caused any tear flow. The Schirmer test is only a confirmatory test and will not definitely establish the diagnosis of keratitis sicca.

The use of rose bengal dye is equally, if not more valuable in diagnosing keratitis sicca, the most common abnormality of the tear film. The characteristic punctate red stain appears at the lower limbus or in the exposed portion of the cornea and conjunctiva in the interpalpebral fissure. A careful history is very important for patients in whom one considers the diagnosis keratitis sicca. Frequently arthritis, a dry mouth, dry nasal mucous membranes or a collagen disorder may be present. Should keratitis sicca be suspected from the symptoms, Schirmer and rose bengal tests, a trial of therapy is indicated. Methyl cellulose or a similar substance such as polyvinyl alcohol applied hourly may relieve the complaints and provide therapeutic backing for the diagnosis.

In several corneal diseases it is important to test for the presence or absence of corneal sensitivity. This is frequently tried with a wisp of cotton, but is difficult to evaluate. There cannot be uniform stimulation to the cornea when the two eyes are compared and the irregular cotton strands may touch the lashes and cause premature blinking. A simple instrument known as the aesthesiometer is employed to compare the sensitivity of one eye to the other (Fig. 2). This instrument consists of a calibrated nylon filament which is set at various lengths and applied to the corneal surface until the smallest bend is visible in the filament (Fig. 3). This is the end point and is noted. The sensitivity is measured bilaterally since in the elderly, or with patients who cannot respond satisfactorily (language or mental barrier), there may be an apparent diminished sensation in both eyes. If only one eye were tested, a false decrease in touch threshold would be found. Corneal scarring from herpes simplex keratitis is very common, and can be quickly differentiated from scarring due to injury or bacterial infection using this instrument. In herpes the sensitivity is usually diminished even years after the infection has healed, whereas in other scars the sensitivity frequently returns to normal. Although herpes zoster and neuroparalytic keratitis also cause

decreased corneal sensitivity, these diseases are very uncommon in comparison to herpes simplex disease of the cornea. It is particularly important to differentiate this disease since recurrences of corneal ulcers which are not characteristically dendritic are sometimes treated with local steroid which is contraindicated in herpes simplex keratitis.

Another small hand instrument, useful in establishing early changes in the cornea when they are obscure with the biomicroscope, is the keratoscope or placido disc. This is an illuminated instrument with concentric circles around a central small lens opening. The concentric circles are reflected off the corneal surface and the physician, through the central lens, is able to observe the conformity of these circles. The early changes in several diseases are made more apparent with the use of this disc. Early keratoconus, which is frequently difficult to diagnose with the slit lamp, may be visualized more easily with the placido disc. The circular rings appear closer together in one segment of the cornea than they do in the other quadrants when keratoconus is present.

Epithelial edema, when it is just beginning, may cause minimal blurring of vision and be very difficult to distinguish with the slit lamp. Dystrophic changes in the basement of Bowman's membrane which have the appearance of ground-glass, can be mistaken for epithelial edema. If the keratoscope is used, the circular rings will appear diffuse and not sharp with epithelial edema, as contrasted to a sharp reflex when a dystrophy in Bowman's membrane is present. The irregularity produced by early epithelial edema is therefore more quickly recognized with the placido disc.

In summary, the use of special dyes such as fluorescein and rose bengal can help distinguish certain disease entities in the cornea and conjunctiva before advanced changes are noted. The Schirmer tear test, corneal aesthesiometer and placido disc are also useful in distinguishing diseased conditions of these tissues and are easily handled, inexpensive and readily available to the physician.

■ *Dr. Laibson is an associate at Wills Eye Hospital and Research Institute, Philadelphia.*

**Through
these doors
pass the
world's best
excuses
for not using
safety belts.**



Advertising contributed
for the public good.





The Hospital of the University of Pennsylvania

OEO Neighborhood Health Centers

The Poor and You

By MATTHEW MARSHALL, M.D., Pittsburgh

In 1966, the Comprehensive Area-wide Health Planning Act (PL 89-749) was passed. It is obvious that within the next few years the scope, complexity and intensity of planning for health care services will increase markedly. Ostensibly the act states that it will not interfere with existing patterns of private professional practice of medicine or dentistry, but the guidelines contain no suggestions as to how the patterns of private health care may be preserved.

Organized medicine has two possible courses of action. The first is to ignore it. This allows those who are responsible for implementing the act no alternative but to seek physicians' advice, when and if they want it, from those they select. It allows no alternative for organized medicine but to accept or attempt to repeal policies they had no voice in making. Involvement provides an opportunity for channels of advice from those who

are engaged in patient care. It involves cooperation with programs almost certain to have some features more or less unpalatable to organized medicine. It does not guarantee that our advice will be accepted. The second alternative has been the general policy of organized medicine, but there are some members and physician organizations who believe that we should divorce ourselves from any efforts toward cooperation with government, voluntary planning groups, third-party payers, and even our medical committees that recognize the need of professional self-discipline and the public's desire to insure its medical costs. In my opinion, since all voluntary planning depends upon voluntary cooperation, success of these efforts is as likely to expedite a full system of government control of medicine, as the efforts of those who frankly endorse socialized medicine.

Planning becomes increasingly ur-

gent, because the complexity of medicine and increased public demand has created a relative shortage of practicing physicians. This is most acute in the field of personal physicians. Paradoxically, many of these physicians are in the age group where the effects of planning will not have a substantial affect upon their lives and life goals, and therefore, these efforts may well be of least concern to those whom we might normally expect to be most concerned. Planning will relate to physician supply, organization, quality, efficiency and cost. Whose concern is this? Chaos will most certainly occur without professional guidance. From what sources will it come?

Planning for the improved delivery of ambulatory physician services for the poor has a far greater significance than may be apparent. The concentration of physicians has been proportionate to community income so

the physician shortages are relatively more acute and the choice of physician and hospital has been more restricted to the poor. Many physicians have not accepted free or public assistance patients. Traditionally, the poor have been cared for in the charity clinic by salaried house officers under a variable degree of supervision by attending staff, and, more than realized, by some family physicians willing to accept some free patients in a predominately private practice. There are a relatively few physicians who have practiced in the ghetto and adapted to its problem. For the most part these physicians have not joined the activities of organized medicine, have been ignored by the OEO and have been more frequently criticized than praised, except by their ghetto patients who recognize them as their "comprehensive health care source."

The hospitals have stepped into the gap offering themselves as the resource responsible for health in the area. They do this by offering a modernized version of their clinic to the community, called hospital based group practice. The typical OEO neighborhood health center hires physicians on a salaried basis with funds sufficient to make this position more attractive financially and to free it of the responsibilities for care when the physician is away from his practice. This is an extension of the type of privileges currently enjoyed by house officers and something the hospitals have learned they must offer if they are to have any house officers. The solo practitioner, as he becomes increasingly harried, must wonder why he should not avail himself of such an opportunity. Who can criticize him or the hospitals for stepping into this gap? An available clinic system is better than an unavailable one.

The system we are developing for the poor will be gradually extended into the more affluent communities as the physician shortage grows more acute. Unquestionably, hospitals have a vital community responsibility to provide needed highly sophisticated services and facilities, but it is physicians who are licensed to be responsible for their patients' care. It is the physicians on the staffs of the various hospitals who have the basic responsibility for developing the emergency system to a high degree of effectiveness. It is our responsibility to develop better ambulatory care system. The key question is: Does anyone in our time care whether we have

personal physicians responsible to their patients, dependent upon and wedded to their practice rather than looking for a living toward the Board of Directors of a hospital or clinic? Do the poor, the middle class, or the rich want their physicians to be basically responsible to someone else?

The current challenge is clearly to develop a private practice of medicine in poor areas which can be assimilated into the mainstream of modern medical care. Of course, there must also be better educational and job opportunities, gainful employment, private housing and private medical care.

Success depends upon whether conditions can be created that will entice physicians to practice in a poor section on a private basis. Is it possible to create here all the conditions of the modern practice of medicine?

Can recognition of this task be placed in the category that will recognize those who treat the poor at home as well as those who treat them in Afghanistan? Not without community assistance.

Can we assure a prospective physician access to an accredited hospital in accordance with professional standards? No problem.

Can he have a private office that is physically attractive and functional? Not currently.

The cost of development of private offices in poverty areas to provide space for the extra personnel needed to provide care for the poor probably exceeds the cost for similar development in better neighborhoods populated by better educated and more conventionally motivated people. The Alleghany County Medical Society has been asked to explore doing this, and I believe that if there were assurance of some government supplied funds, we could meet this challenge at substantially less public cost, because the private physician would be motivated to have the maximum concern for effective expenditure from his own pocket and more intimate knowledge of the actual needs of his patients that he must meet if he is to build his practice. It is not presently possible to make a practice with a substantial load of DPA or Medicaid patients competitively attractive. And the only additional source of payment for these patients is an OEO Health Center, Appalachia program, or funds that hospitals can divert from some other source. Under each of these conditions, the physician would be

employed by a board rather than his patients.

Can we assure such a physician, attempting to be a personal physician, that his case load will not overload him and that he will have some understanding of, and relief from the constant harassment of such a practice? Rather clearly this is not possible unless he can practice in some kind of an association with at least several other physicians, can utilize physician-assistants and public health services easily and effectively. Help could be accomplished with the assistance of physicians already practicing in the community as long as it can be demonstrated that such an association would provide better time off for them too, and have no significant affect upon their income. Can more physician-assistants be utilized by established or practicing physicians? There are still many problems only partially recognized in the proper training, licensing, and legal responsibility of such assistants. Effective use of such assistants must be financially practicable to both the physician and his assistant. This will not occur until there is an upward adjustment of the house call fee so that low fees for assistants would make their services acceptable. A great deal of co-operation will be required to make this kind of assistance practical. Currently the potential is more theoretical than practical.

At this time I believe that our efforts to improve and promote private health care in poor areas are blocked, because of inadequate federal tax funds under Medicaid (about \$20.00 per capita in Pennsylvania) to subsidize physician services, while substantially more federal funds are available for selected groups of the poor so long as they are willing to abandon a private basis of care. (About \$80.00 per capita for OEO Health Centers)

Is it too much to expect that the comprehensive health planning act that guarantees planning will not interfere with existing patterns of private professional practice, will find the ways to effectively encourage other governmental agencies not to discriminate against private practitioners and that governmental lobbies as well as the lobby of the Pennsylvania Hospital Association will support payment to physicians for ghetto services at rates at least comparable to those that hospitals can obtain and pay a physician for providing the same service?



No one who is connected with a college or a university needs to be told that institutions of higher learning are now registering and graduating more students than ever before in our history, and that even greater peaks in enrollment are envisioned in the immediate future. Between registration and graduation these students indulge in an almost infinite variety of activities. Among their organized activities none is more highly visible than the intercollegiate sports program.

Not only are more students candidates for intercollegiate sports, but smaller colleges growing into larger ones, and larger ones into universities, have found that their entrance into sports programs has been as important in their quest for national recognition as the size of their library or the excellence of their faculty. Not only do four year colleges have sports programs, but many of the rapidly multiplying community colleges and junior colleges have sizable programs of their own. Colleges which some years ago supported only football, basketball and baseball, now field teams in soccer, swimming, gymnastics, wrestling, tennis, fencing, golf, lacrosse and crew, not to mention polo, squash, judo, volleyball, etc. Such is the tendency of sports to multiply and remain on the scene that only one sport has virtually disappeared from college campuses today, and that is boxing, which now numbers only four schools as its sponsors.

Not only are intercollegiate sports blooming today but intramural sports programs have multiplied many times over as far as participation is concerned since there is no natural limitation, such as having only one varsity team in each intercollegiate sport. And now, after a long period of gestation, women's intercollegiate sports have burst forth on the scene and will rapidly assume an importance parallel to men's intercollegiates.

With the burgeoning of their student populations colleges have had to expand existing health services enormously, and to create them where they did not previously exist. In spite of the great increases in employment of full and part-time physicians on college campuses, no college seems to be able to meet the demands, even though many are as fully staffed as their current budgets will allow. Problems of philosophy, as to how far the college should go in meeting the health needs of its students, are involved in securing the necessary allocations of funds.

Postgraduate Training In Sports Medicine

by ALAN F. RYAN, M.D.
Madison, Wisconsin

PENNSYLVANIA MEDICINE



Problems of procurement arise from the fact that physicians are at the moment in relatively scarce supply and the rewards of private practice are extremely lucrative.

In the meantime a great body of knowledge relating to all medical aspects of sports has been accumulating. Although the first books on this subject in English were published only as recently as 1931, Sports Medicine has become a field of specialty practice in medicine in the United States, as it had already been for some years in Europe. At the present time the field of Sports Medicine may be considered to include not only the medical supervision of athletes but also the areas of medical responsibility in Adaptive Physical Education, Preventive Exercise and Therapeutic Exercise. It is no longer possible to function effectively as a medical consultant in this field without the special knowledge and experience which can best be obtained through special training.

Although formal training programs in Sports Medicine at university medical schools in Europe leading to diplomas and degrees have been established for some time, until this past year there has not been such a program in the United States. European programs of preparation in Sports Medicine have been generally of two types: one is integrated with the general course of medical studies; the other is a post-graduate program of study for one or more years.

The course in Sports Medicine for physicians which has been established at the University of Wisconsin extends from September 1 to May 1 of the following year. Its presentation involves cooperation between the departments of surgery, physical education, athletics, and nutrition and the university health service. The time is equally divided between classroom and laboratory sessions and practical work with the sports teams at the university. The practical work also includes making

some trips with selected teams.

The subjects covered in the classroom and laboratory work include: the anatomy and pathology of sports trauma; the physiology of exercise; athletic training and conditioning; rehabilitation following sports trauma; the use of protective equipment in sports; the relation of sports techniques to the occurrence of injury; the physical examination of the athlete; women in sports; the nutrition of the athlete; the psychology of the athlete. Each physician is encouraged to follow up some particular line of investigation and prepare a short paper describing it.

In the training room and in the field the physicians work directly with the trainers and the athletes exercising individual responsibility under supervision for diagnosis and treatment. They have experience with pre-competition physical examinations as well as all other aspects of the medical care of varsity and freshman athletes.

In order to assess the present practices and hopes for the future of colleges and universities in the United States and Canada with regard to the type of medical supervision offered for their intercollegiate sports programs, a brief survey by mail was conducted early this year among those institutions belonging to the American College Health Association. Five hundred fifty-four questionnaires were sent out and 163 returned. Eleven were returned from women's colleges who were conducting little or no intercollegiate sports activity and 3 from institutions that do not have undergraduate student bodies. The remaining 148 questionnaires were divided into two groups. Thirty institutions were identified as having very small undergraduate bodies and minimal intercollegiate programs. The remainder were either large institutions or had very active intercollegiate programs in spite of their small size.

The first question asked was "Do you now employ a physician who has special responsibility for the medical supervision and care of your athletes?" Among the small group, eight answered yes and twenty-two no. In three cases the director of student health services indicated that this was his responsibility. In three cases a physician in private practice was employed for this purpose on a part-time basis. In two cases, physicians working full-time in student health had this as a part-time responsibility. In the large group, eighty answered yes and only thirty-eight answered no. Many indicated that the physician who had this responsibility was employed by the athletic department alone and had no relationship to student health. A few said that the special assignment of a physician to sports applied only to football and was on a part-time basis.

The second question asked was "If so, does he have full-time status?" and the third question was "If he is on full-time status, is this his sole responsibility?" Among the small group all answered the second question "no" and therefore did not have to answer the third one. Among the large group seventy-nine indicated that the physician responsible for sports medicine was part-time in that area and about 50 percent spent their other time working in other aspects of the student health service. There was only one physician identified as a full-time sports physician with no other responsibilities. Ten physicians who

were full-time in the student health service indicated that they spent about 50 percent of their time caring for athletes.

The fourth question was, "If he is on part-time status, is this his sole responsibility as it relates to the student health service?" Among the small group three answered "yes" and twenty-seven "no." Among the large group, the replies were very mixed, but the general pattern was that if the physician engaged in sports medicine was on a part-time basis he was usually a man in private practice, specially employed for sports and frequently by the athletic department.

The fifth question was "Would you be interested in securing the services of a physician with special training in Sports Medicine who would have as his principal responsibility the medical care and supervision of your athletes on a full-time or part-time basis?" Among the small group eight answered yes, but specified that this would have to be a full-time appointment with half-time devoted to other work in the student health service. Among the large group thirty-five said "yes;" twenty-one said "yes," but qualified it by saying that it would not be possible at present, and sixty-two said "no."

The sixth question was, "Would you be interested in sending one of your present staff for a full year's training in Sports Medicine?" Among the small group two said "yes" and the rest "no." In those who said "yes" as well as those that answered "yes" to the preceding question, the implementation would depend on the fu-

ture availability of funds and personnel. Among the large group only six answered "yes" to the sixth question, but ten indicated they would like to do this eventually. Twenty-four indicated that they would be interested but had no one available they could spare. Seventy-three answered an unqualified "no" and five said that they would be interested in sending someone to take a much shorter course.

To summarize the results of the questionnaire it might be said generally that colleges and universities today recognize the importance of the medical supervision of sports by assigning one or more physicians specific responsibilities in this area. With a very few exceptions, where this is not done it is simply due to the lack of sufficient personnel to make such a specific assignment. The lack of personnel can be traced to two sources, difficulty in recruitment and budgetary limitations.

A considerable number of institutions employ a physician or group of physicians through the athletic department to care for the athletes in intercollegiate competition. There is no direct relationship with student health. All of these physicians in the group responding to the questionnaire are in private practice and serve the university only on a part-time basis. Many are orthopedic surgeons.

Only one institution in the entire group responding to the survey employs a physician on a full-time basis whose sole responsibility it is to provide medical supervision for intercollegiate sports. Where full-time student health personnel are assigned responsibilities for sports medicine in all other institutions they apparently devote an equal amount of time to other student health problems.

The larger and more active institutions today are thinking in terms of assigning one physician the responsibility for Sports Medicine who would have special training in this area. The immediate desire for such personnel is such that it would take a number of years to satisfy it with the graduates of the only existing full-time training program in this field. If staff positions and funds to support them and some financial support for training in this field would be forthcoming the demand would be immediately doubled. At the present time not less than ten of the institutions responding to the survey are actively seeking for full-time employment physicians with special interest and training in Sports Medicine.



Dr. Ryan is associate professor of physical education at the University of Wisconsin, Madison.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



**A realistic
approach
to pain
relief**

Empirin[®]

**Compound with Codeine
Phosphate gr. 1/2 No. 3**

Each tablet contains:

Codeine Phosphate gr. 1/2 (Warning—
may be habit forming), Phenacetin gr. 2 1/2,
Aspirin gr. 3 1/2, Caffeine gr. 1/2.

**Keeps the promise
of pain relief**

W. & Co.' narcotic products are
Class "B", and as such are available on oral
prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.





Louie!
You're
back.

Louie lost weeks with acute shoulder bursitis. That's a lot of pain, stiffness and tenderness...and also a lot of fish. It might have been different with **Butazolidin® alk**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forget it.

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a

latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-B

**For complete details,
please see full prescribing information.**

Geigy Pharmaceuticals 
Division of Geigy Chemical Corporation
Ardsey, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

When it's more than a bad cold



**your patient can feel better
while he's getting better**

Achrocidin[®]

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN[®] Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and

may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.





Cardiogenic Shock

Part I

What is cardiogenic shock?

In its pure form it is a state of shock arising from severe malfunction of the heart, usually acute in onset and most often associated with hypotension. There are signs of systemic hypoperfusion due to failure of the heart to produce a sufficient output of blood under conditions of normal venous return.

You appear to imply that cardiogenic shock is not always "pure".

Cardiogenic shock is almost never exclusively the result of myocardial dysfunction. The three major determinants of circulation, heart, blood and vessels, are physiologically in a dynamic state of balance. Severe disturbance of one factor will affect the others. This is also true when shock has other backgrounds. For example, severe hemorrhagic shock leads eventually to impaired cardiac function and cardiogenic factors may become a major complication. Conversely, in the patient with severe heart disease the development of shock is influenced by a number of factors, namely, function of the heart, composition and volume of the blood and state of the peripheral circulation. These modifying factors determine whether the failure of cardiac pumping action results in pulmonary edema or shock or a combination of both.

What cardiac factors lead to cardiogenic shock?

The common feature is low cardiac output. Arrhythmias can have this effect, either by a very slow pulse rate, as in complete heart block, or by extremely low stroke volume resulting from poor diastolic filling, as in certain rapid arrhythmias. In the absence of a severe arrhythmia a fall in cardiac output may be caused by a reduction in myocardial contractility. This situation prevails in acute myocardial infarction, since part of the myocardium is unable to contract forcefully, and in severe chronic coro-

nary heart disease with fibrous replacement of much of the myocardium. It also occurs in diffuse myocardial disease, such as myocarditis, in states of severe anoxia, including pulmonary embolism, in metabolic derangements (acidosis or hyperkalemia), in drug effects (myocardial depressant agents), or in intoxications (alcohol, arsenic and many others).

Is there a specific level of cardiac output at which cardiogenic shock occurs?

Although low cardiac output is the common feature of all cases of cardiogenic shock, there is no numerical relation. In myocardial infarction, for example, a patient with pulmonary edema may have a very low cardiac output but may still not present symptoms of shock. Extracardiac factors account for the different circulatory responses.

What are these extracardiac factors?

The response of the peripheral circulation is crucial. Constriction of the arterioles is expected to occur as a result of a catecholamine response to low cardiac output. This results hemodynamically in increased systemic vascular reactivity. This can occur after morphine and other sedatives or in patients with antihypertensive medications, especially ganglionic blocking agents. Catecholamine depletion by reserpine or guanethidine, sympathetic fatigue from severe debilitating illnesses, or acidosis can likewise be incriminated. Finally, we must mention structural abnormalities of the vessels, such as arteriosclerosis or amyloidosis. Thus, diminished arteriolar reactivity can account for the finding of "warm" cardiogenic shock associated with vasodilatation. Simultaneously with arteriolar constriction in shock, there also occurs constriction of the vessels on the venous side of the capillary bed. This process, too, is mediated by catecholamines. Mobilization of blood from venous pools

and increased diastolic filling of the heart result, and the reflex mechanisms may fail with a resulting fall of venous return. If the venous constriction is out of proportion to the arteriolar constriction, there will be increased trapping of blood in capillaries with increased capillary pressure and loss of fluid from the vascular bed by capillary leakage.

From this it appears that an actual reduction in blood volume may be a complication of cardiogenic shock.

Yes, especially in patients receiving diuretics or after successful treatment of pulmonary edema.

■ **John H. Moyer, M.D.**, Professor of Medicine and Chairman, Department of Medicine, Hahnemann Medical College and Hospital, talks with Peter Sigmann, M.D., Senior Instructor in Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

■ **William G. Leaman, Jr., M.D.**, Fellow, Council on Clinical Cardiology of the American Heart Association, edited this Brief for the Council on Science and Education, in cooperation with the Pennsylvania Heart Association.

About that
excuse for not
wearing your
safety belts:
It isn't
good enough.

Do you have patients who try to hide frustration behind conformity?

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you.

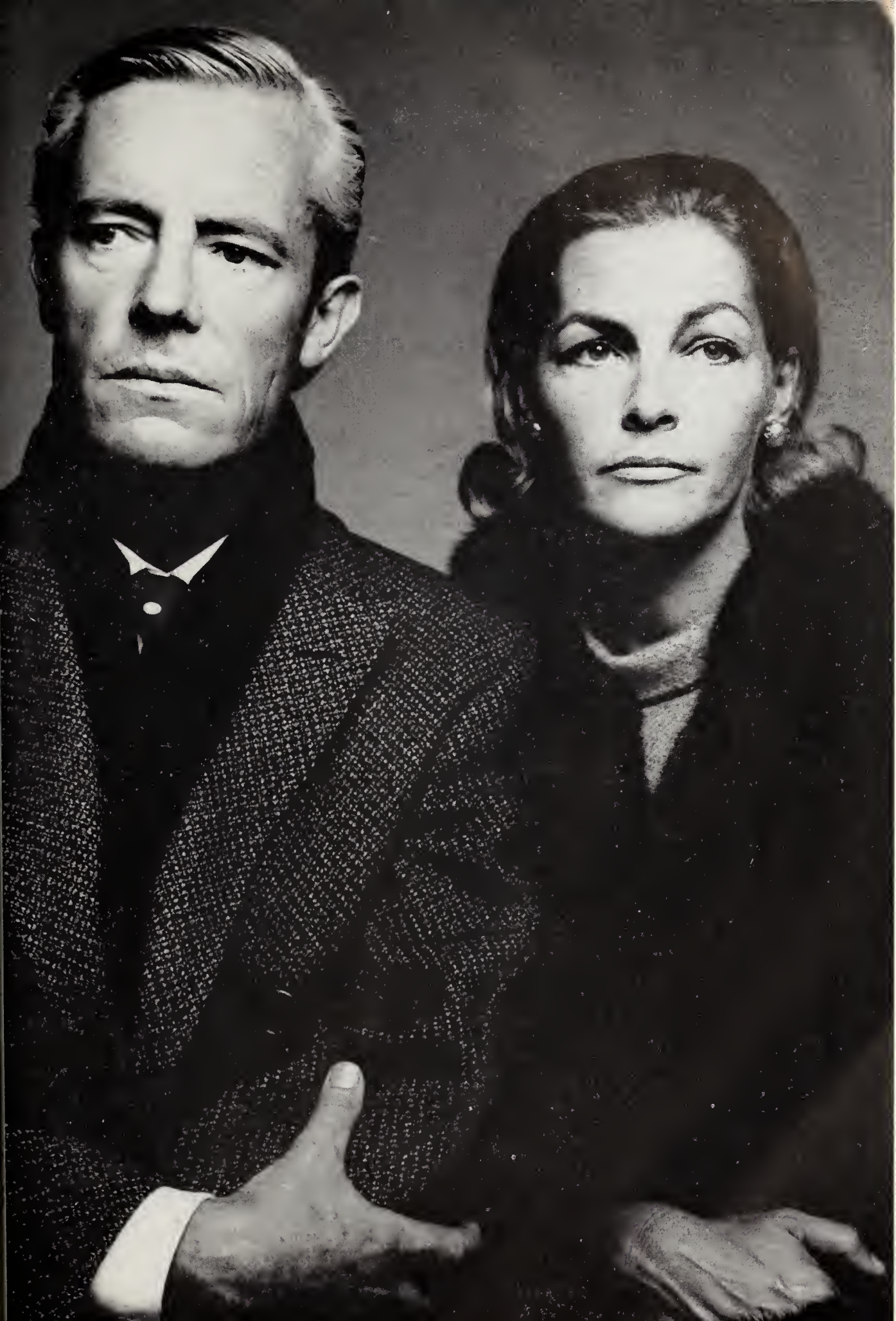
Whether depression is open or secretive, Aventyl HCl assists in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.

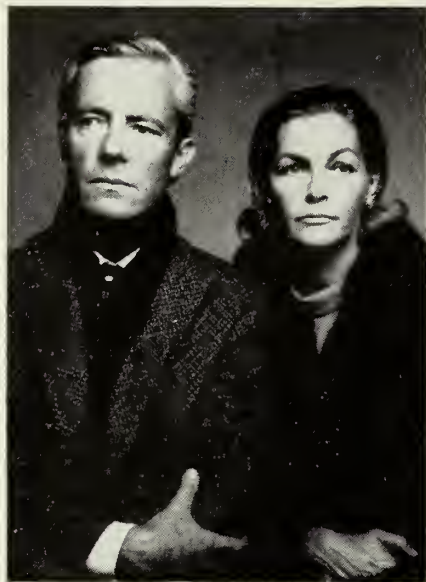


Eli Lilly and Company
Indianapolis
Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline Hydrochloride





Aventyl® HCl

Nortriptyline Hydrochloride

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two months after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic pur-

pura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl® HCl (nortriptyline hydrochloride, Lilly) under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily

10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily

10 mg.—Ages three to six, 1 Pulvule one to three times daily

Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily

Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500.

Additional information available to physicians upon request.



Eli Lilly and Company
Indianapolis
Indiana 46206



○ Indicates courses being conducted in Pennsylvania.

ANESTHESIOLOGY

○ **A Review of Recent Advances in Anesthesia;** by Jefferson Medical College and York Hospital; at *York, Thursday, April 17, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

ARTHRITIS & RHEUMATISM

○ **A New Look at Rheumatoid Arthritis;** by Jefferson Medical College and York Hospital; at *York, Thursday, January 9, 1969*; fee \$50 for 112 hours, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **The Fibrositis Syndrome (Psychogenic Rheumatism?);** by Hahnemann Medical College, at Community General Hospital, *Reading, Wed., February 5, 1969*; 9:30 a.m.-10:30 a.m.; contact Charles N. Wang, M.D., 145 North 6th St., Reading, Pa. 19601.

○ **Rheumatoid Arthritis — Diagnosis and Management;** by Hahnemann Medical College and Grand View Hospital, Sellersville; at Grand View Hospital Nurses Home, *Sellersville, Wednesday, March 26, 1969*; 10 a.m.-noon.; contact D. Henry Ruth, M.D., Grand View Hospital, Sellersville, Pa. 18960.

○ **Rheumatology;** by Harrisburg Hospital, *Harrisburg, Tuesday, May 13, 1969*; 5:00 p.m. Contact: W. Smith, M.D., Medical Director, Harrisburg Hospital, Harrisburg 17101.

○ **CPC and Rheumatoid Arthritis;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, May 19, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **M/M and Gout and Pseudogout;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, May 26, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

MISCELLANEOUS BASIC SCIENCES

○ **M/M and Component Therapy;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical

Center, *Chester, Monday, February 24, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

BIOCHEMISTRY

○ **Bile Salts;** by Jefferson Medical College and Penn State University; at *Allentown Hospital, Thursday, March 13, 1969*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

CARDIOVASCULAR DISEASE

○ **The Physician and His Role in the Prevention of Coronary Disease;** by Jefferson Medical College and York Hospital; at *York, Thursday, December 12, 1968*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Full Day Visit —with afternoon rounds. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Digitalis Intoxication;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, January 6, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Selected Topics in Cardiac Disease;** by Western Pennsylvania and Shadyside Hospitals; at *West Penn Hospital, Sunday, February 9, 1969* and *Shadyside Hospital, Sunday, February 16, 1969*; 1:00 p.m. to 5:00 p.m.; luncheon 12 noon to 1:00 p.m. each Sunday; fee \$15; AAGP 8 hours. Contact John B. Hill, M.D., The Western Pennsylvania Hospital, 4800 Friendship Ave., Pittsburgh 15224.

○ **Symposia on Management of the Patient with Peripheral Vascular Disease;** by Jefferson Medical College and Penn State University; at Mercy Hospital, *Scranton, Wednesday, February 19, 1969*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Intractable Congestive Heart Failure;** by Hahnemann Medical College and Grand View Hospital, Sellersville; at Grand View Hospital Nurses Home, *Sellersville, Wednesday, February 26, 1969*; 10:00 a.m.-noon. Contact D. Henry Ruth, M.D., Grand View Hospital, Sellersville, Pa. 18960.

○ **Coronary Artery Disease; Pre-Infarction and Post-Infarction. Problems of Recognition and Management;** by Jefferson Medical College and Penn State University; at *Williamsport Hospital, Wednesday, March 19, 1969*; 11:00 a.m. to 2:30 p.m.; AAGP 3 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Renovascular Hypertension;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, March 31, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Prosthetic Valve Replacement;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, April 7, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Advances in Cardiology;** by Hahnemann Medical College & Hospital at Marriott Motor Hotel, City Line Avenue & Monument Road, *Philadelphia, April 16 and 17, 1969*; \$50 fee AAGP credit applied for. Contact: Albert N. Brest, M.D., Hahnemann Medical College, 230 N. Broad Street, Philadelphia, Pa. 19102.

○ **CPC and Congenital Heart Disease;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, April 21, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Changing Concepts in the Therapy of Congestive Heart Failure;** by Hahnemann Medical College, at Community General Hospital, *Reading, Wednesday, May 7, 1969*; 9:30 to 10:30 a.m. Contact Charles N. Wang, M.D., 145 N. 6th St., Reading, Pa. 19601.

○ **Interpretation of Cardiac Arrhythmias;** by Hahnemann Medical College and Hospital; at Marriott Motor Hotel, *Philadelphia, July 14-18, 1969*; fee \$150; maximum permitted 75. Contact Leonard S. Dreifus, M.D., Hahnemann Medical College and Hospital, 230 N. Broad St., Philadelphia 19102. All day—Monday through Friday.

CHEST DISEASES

○ **Treatment of the Patient with an Isolated Pulmonary Lesion;** by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, December 12, 1968; 11:30 a.m. to 2 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Courses in Bronchoesophagology;** by Temple University School of Medicine and Hospital; at Temple University Health Sciences Center, 3401 N. Broad St., Philadelphia, Monday, January 13-24, 1969; Monday, April 14-25, 1969; fee for course \$350. Contact Charles M. Norris, M.D., or Gabriel F. Tucker, Jr., M.D. at Chevalier Jackson Clinic, Temple University Hospital, 3401 N. Broad St., Philadelphia 19140.

○ **Atypical Pulmonary Infections;** by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, February 20, 1969; 8:45 a.m. to 12:30 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Pulmonary Physiology;** by Division of Graduate Medicine, School of Medicine, University of Pennsylvania; at *Philadelphia, Monday, March 3-7, 1969*; fee \$75; minimum required 20, maximum permitted 50. Contact Paul Nemir, Jr., M.D., Director, Division Graduate Medicine, 237 Medical Laboratories, Philadelphia 19104.

○ **Pulmonary Diseases;** by Division of Graduate Medicine, School of Medicine, University of Pennsylvania; at Graduate Hospital of the University of Pennsylvania, Philadelphia, Monday, March 10-21, 1969; fee \$150; minimum required 20, maximum permitted 50. Contact Paul Nemir, Jr., M.D., Director, Division Graduate Medicine, 237 Medical Laboratories, Philadelphia 19104.

ELECTROCARDIOGRAPHY

○ **Advanced Electrocardiography;** by Albert Einstein Medical Center; at *Philadelphia, Wednesday, February 26-April 30, 1969*; AAGP 30 hours; maximum number permitted 18; fee \$60. Contact Solomon Mintz, M.D., Albert Einstein Medical Center, York and Tabor Roads, Philadelphia 19141.

○ **Clinical Electrocardiographic Interpretation;** by Hahnemann Medical College and Luzerne County Academy of General Practice; at *Wyoming Valley Hospital, Wilkes-Barre, Wednesdays, April 2-June 4, 1969; 10 a.m. to 1:00 p.m.* Contact David Kistler, M.D., 171 Stanton St., Wilkes-Barre 18702.

○ **Clinical Electrocardiographic Interpretation;** by Hahnemann Medical College & Hospital; at *Marriott Motor Hotel, Philadelphia, Monday to Friday, July 7-11, 1969*; fee \$100. Contact Leonard S.

Dreifus, M.D., Hahnemann Medical College and Hospital, 230 N. Broad St., Philadelphia 19102.

ENDOCRINOLOGY

○ **Endocrinology;** by Jefferson Medical College; at *Philadelphia, Tuesday, January 7-February 11, 1969*; 12 course hours; AAGP credit applied for; fee \$50; minimum number required 30, maximum permitted 100. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Modern Treatment of Diabetes;** by Hahnemann Medical College; at *Community General Hospital, Reading, Wednesday, January 8, 1969; 9:30 to 10:30 a.m.* Contact Charles N. Wang, M.D., 145 N. 6th St., Reading, Pa. 19601.

○ **Abnormalities of Adrenal Function;** by Jefferson Medical College and Penn State University; at *Crozer-Chester Medical Center, Chester, Monday, May 12, 1969; 2:00 to 5:00 p.m.*; AAGP 2 hours. Contact John F. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Disorders of the Adrenal Gland;** by Jefferson Medical College and Penn State University; at *Mercy Hospital, Scranton, Wednesday, May 21, 1969*; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

GASTROENTEROLOGY

○ **Symposia on Hepato-Biliary Problems;** by Jefferson Medical College and Penn State University; at *Mercy Hospital, Scranton, Wednesday, December 18, 1968*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **CPC and Evaluation of Jaundice;** by Jefferson Medical College and Penn State University; at *Crozer-Chester Medical Center, Chester, Monday, January 20, 1969; 2:00 to 5:00 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **The Evaluation of Pancreatic Disease;** by Jefferson Medical College and Penn State University; at *Crozer-Chester Medical Center, Chester, Monday, February 10, 1969; 2:00 to 5:00 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Dilemmas of a Belly Ache;** by Jefferson Medical College and Penn State University; at *Williamsport Hospital, Wednesday, February 19, 1969; 11:00 a.m. to 2:30 p.m.*; AAGP 3 hours. Contact John H. Killough, M.D., Jefferson

Medical College, 1025 Walnut St., Philadelphia 19107.

○ **The Mechanisms and Diagnosis of Jaundice;** by Hahnemann Medical College, at *Community General Hospital, Reading, Wednesday, April 2, 1969; 9:30 to 10:30 a.m.* Contact Charles N. Wang, M.D., 145 N. 6th St., Reading, Pa. 19601.

○ **Surgical Diseases of the Gastrointestinal Tract;** by University of Pennsylvania School of Medicine, Philadelphia, April 7-18, 1969. Maximum number: 75. \$200 fee. Contact Paul Nemir, Jr., M.D., 237 Medical Lab. Building, Philadelphia, Pa. 19104.

GENERAL MEDICINE

○ **Panel Discussion on Drug Addiction;** at *Harrisburg Hospital, Harrisburg, Tuesday, December 10, 1968; 5:00 p.m.* Contact W. Smith, M.D., Medical Director, Harrisburg Hospital, South Front Street, Harrisburg 17101.

○ **Antibiotics: An Updating;** by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, December 19, 1968; 8:45 a.m. to 12:30 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Impact of Hallucinogenic Drugs;** by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, January 9, 1969; 11:30 a.m. to 2 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **The Changing Patterns of Medical Care;** by Jefferson Medical College and York Hospital; at *York, Thursday, February 20, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Sixth Annual Medical Lecture Series;** at *Delaware County Memorial Hospital, Drexel Hill, Tuesday, February 25, 1969 to April 1, 1969*; course hours 12; fee \$20; AAGP credit applied for; minimum number 20, maximum 75. Contact Edwin D. Arsht, M.D., Delaware County Memorial Hospital, Lansdowne & Keystone Avenues, Drexel Hill 19026.

○ **Silicosis and Anthracosilicosis;** by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, March 6, 1969; 8:45 a.m. to 12:30 p.m.*; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Endoscopy with Fiberoptics;** by Jefferson Medical College and Penn State University; at *Crozer-Chester Medi-*

cal Center, *Chester, Monday, March 10, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **The Newer Antibiotics**; by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, March 13, 1969*; 11:30 a.m. to 2 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Controversy in Hospital Infection**; by Western Pennsylvania and Shadyside Hospitals; at *West Penn Hospital, Sunday, March 16, 1969*; 10:30 a.m. to 4:30 p.m.; fee \$15; AAGP 5 hours. Contact John B. Hill, M.D., The Western Pennsylvania Hospital, 4800 Friendship Ave., Pittsburgh 15224.

○ **Management of Shock and Fluid Therapy**; by Western Pennsylvania and Shadyside Hospitals; at *West Penn Hospital, Sunday, March 23, 1969*; 10:30 a.m. to 4:30 p.m.; fee \$15; AAGP 5 hours. Contact John B. Hill, M.D., The Western Pennsylvania Hospital, 4800 Friendship Ave., Pittsburgh 15224.

○ **The Family Doctor, The Pediatrician, and Surgical Care of Children**; at *York, Thursday, April 3, 1969*. (See Surgery for complete information.)

○ **Headache**; by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, April 3, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Acute Medical Emergencies**; by Episcopal Hospital, *Philadelphia, Thursday, April 10-June 12, 1969*; fee \$20; minimum number required 25, maximum permitted 50. Contact Karel Douwes, M.D., Episcopal Hospital, Front St. and Lehigh Ave., Philadelphia 19125.

○ **Current Concepts in Medicine for the Practicing Physician**; 3rd Annual Main Line Conference of Bryn Mawr Hospital and Montgomery County Chapter, AAGP; at Treadway Inn and Bryn Mawr Hospital, Lancaster Ave., *St. Davids, Thursday, April 24-26, 1969*; fee \$35. Contact John B. Magee, M.D., Bryn Mawr Hospital.

○ **Treatment of Shock**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, May 5, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **New Techniques in the Diagnosis of Breast Lesions**; by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, May 8, 1969*; 11:30 a.m. to 2 p.m.; AAGP 2

hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Emergencies in Medical Care**; by Hahnemann Medical College and Hospital; at Marriott Motor Hotel, *Philadelphia, Monday to Friday, December 8-12, 1969*; fees \$150—Paramedics \$35; minimum number required 200, maximum permitted 600. Contact Stanley Spitzer, M.D. or Wilbur W. Oaks, M.D., Hahnemann Medical College and Hospital, 230 N. Broad St., Philadelphia 19102.

GENETICS

○ **Clinical Application of Genetics**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, December 16, 1968*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Genetic Counselling**; by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, February 13, 1969*; 11:30 a.m. to 2 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Genetics**; by Harrisburg Hospital, *Harrisburg, Tuesday, April 8, 1969*; 5:00 p.m. Contact W. Smith, M.D., Medical Director, Harrisburg Hospital, S. Front St., Harrisburg 17101.

GERIATRICS

○ **Minimizing the Hospital Stay of the Geriatric Patient**; by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, February 6, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

○ **Current Concepts in Hematologic Disorders**; by Albert Einstein Medical Center; at Samuel H. Daroff Division, *Philadelphia, Wednesday, January 15-March 19, 1969*; fee \$60. Contact Solomon Mintz, M.D., Albert Einstein Medical Center, York and Tabor Roads, Philadelphia 19141.

○ **CPC and Coagulation Defects**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, February 17, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Hemoglobinopathies**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, April 14, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medi-

cal College, 1025 Walnut St., Philadelphia 19107.

○ **M/M and Diagnosis of Anemia**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, April 28, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Septicemia-A Review of Modern Approaches to a Commonly Missed Diagnosis**; by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, May 1, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

INTERNAL MEDICINE

○ **Clinical Pathological Conference**; by Jefferson Medical College and Penn State University; at Conemaugh Valley Memorial Hospital, *Johnstown, Thursday, December 12, 1968*; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Workshops in the Physiology, Diagnosis and Treatment of Electrolyte and Acid-Base Disorders**; by American College of Physicians; at Hospital and Medical School of the University of Pennsylvania, *Philadelphia, Monday, January 6-10, 1969*; fees: members \$60, non-members \$100. Contact Edward C. Rosenow, Jr., M.D., American College of Physicians, 4200 Pine St., Philadelphia 19104.

○ **Clinical Uses of Adrenergic Blocking Agents**; by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, January 9, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Diseases of Medical Progress: Opportunistic Infections**; by Jefferson Medical College and Penn State University; at *Allentown Hospital, Thursday, January 9, 1969*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Short Course on Renal Disease**; by Jefferson Medical College and Penn State University; at St. Luke's Hospital, *Bethlehem, Thursdays, January 16, February 20, March 20, April 3 and 17, May 15, 1969*; 9:30 a.m. to 12 noon; fees: \$24 for six sessions; \$7 per single seminar; AAGP 3 hours per session. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Chronic Renal Failure**; by Hahnemann Medical College and Grand View Hospital, Sellersville; at Grand View Hospital Nurses Home, Sellersville, *Wednesday, January 22, 1969*; 10:00 a.m. to noon. Contact D. Henry Ruth, M.D., Grand View Hospital, Sellersville 18960.

○ **Antibiotics**; by Harrisburg Hospital, *Harrisburg, Tuesday, February 11, 1969*; 5:00 p.m. Contact W. Smith, M.D., Medical Director, Harrisburg Hospital, S. Front St., Harrisburg 17101.

○ **Differential Diagnosis of Fever**; by Jefferson Medical College and Penn State University; at Conemaugh Valley Memorial Hospital, *Johnstown, Tuesday, February 25, 1969*; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Use and Misuse of Antibiotics**; by Hahnemann Medical College; at Community General Hospital, *Reading, Wednesday, March 5, 1969*; 9:30-10:30 a.m. Contact Charles N. Wang, M.D., 145 N. 6th St., Reading 19601.

○ **Pulmonary Diseases**, by University of Pennsylvania School of Medicine, Division of Graduate Medicine. *Philadelphia, March 10-21, 1969*; maximum number: 50, 7 hours instruction per day; fee \$150. Contact Paul Nemir, Jr., M.D., Director, 237 Medical Lab. Bldg., Philadelphia 19104.

○ **Enzymes**; by Harrisburg Hospital, *Harrisburg, Tuesday, March 11, 1969*; 5:00 p.m. Contact W. Smith, M.D., Harrisburg Hospital, S. Front Street, Harrisburg 17101.

○ **Acute and Chronic Renal Disease and Artificial Dialysis**; by Jefferson Medical College and York Hospital; at *York, Thursday, March 13, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Modern Pathology for Internists**; by American College of Physicians; at University of Pittsburgh School of Medicine and Presbyterian University Hospital, *Pittsburgh, Monday, March 24-28, 1969*; fees: members \$60, non-members \$100. Contact Edward C. Rosenow, Jr., M.D., American College of Physicians, 4200 Pine St., Philadelphia 19104.

○ **Uric Acid Metabolism in Primary and Secondary Gout**; by Jefferson Medical College and York Hospital; at *York, Thursday, March 27, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Glands, Kidneys and Ulcers—An Important and Frequent Connection**; by

Jefferson Medical College and York Hospital; at *York, Thursday, April 10, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Collagen Diseases: Current Concepts**; by Jefferson Medical College and Penn State University; at Mercy Hospital, *Scranton, Wednesday, April 16, 1969*; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Thromboembolic Disease**; by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, April 17, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Clot Lysis**; by Harrisburg Hospital, *Harrisburg, Tuesday, April 29, 1969*; 10:00 a.m. Contact W. Smith, M.D., Medical Director, Harrisburg Hospital, S. Front Street, Harrisburg 17101.

○ **Internal Medicine: The Good That's Old: The New That's Vital**; by American College of Physicians; at Einstein Medical Center, Northern, and Temple University School of Medicine; at *Philadelphia, Monday, May 12-16, 1969*; fees: members \$60, non-members \$100. Contact Edward C. Rosenow, Jr., M.D., American College of Physicians, 4200 Pine St., Philadelphia 19104.

○ **The Pathophysiology, Diagnosis and Management of Proteinuria**; by Jefferson Medical College and Penn State University; at *Allentown Hospital, Thursday, June 12, 1969*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

MALIGNANT DISEASE

○ **M/M and Cancer Chemotherapy**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, January 27, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Treatment of Lymphoma**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, February 3, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Problems in Chemotherapy**; by Jefferson Medical College and Penn State University; at Conemaugh Valley Memorial Hospital, *Johnstown, Tuesday, March 25, 1969*; AAGP 2 hours; no fee.

Contact John H. Killough, Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

MENTAL RETARDATION

○ **Graduate Course in Mental Retardation**; by Elwyn Institute, at *Elwyn, Monday, April 14-18, 1969*; fee \$50; minimum number required 75, maximum permitted 75. Contact Gerald R. Clark, M.D., Elwyn Institute, Elwyn, Pa. 19063.

MICROBIOLOGY & IMMUNOLOGY

○ **What to Learn From a Smear, Culture and Sensitivity**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, January 13, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Immunologic Tools in Hematologic Disease**; by Jefferson Medical College; at *Philadelphia, Tuesday, February 18-March 25, 1969*; 12 course hours; AAGP credit applied for; fee \$50; minimum number required 30, maximum permitted 100. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Immunologic Problems in Clinical Practice**; by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, April 10, 1969*; 11:30 a.m. to 2 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Immunology and Clinical Medicine**; by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, May 1, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

NEUROSURGERY

○ **The Eye and Neurologic Diagnosis**; by Jefferson Medical College and York Hospital; at *York, Thursday, March 6, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

OBSTETRICS & GYNECOLOGY

○ **Some Historical Obstetrical Books**; by Harrisburg Hospital, *Harrisburg, Thursday, December 12, 1968*; 10:30 a.m. Contact: W. Smith, M.D., Medical Director, Harrisburg Hospital, South Front Street, Harrisburg 17101.

○ **New Perspectives: Obstetrics 1968**; by Jefferson Medical College at Jefferson Medical College, *Philadelphia, Friday- and Saturday, December 13 and 14, 1968*;

fee \$35. Contact: John H. Killough, M.D., Ph.D., Jefferson Medical College, 1025 Walnut St., Philadelphia, Pa. 19107. Phone: AC 215-829-6992.

○ **The Physician and Premarital Counseling;** by Jefferson Medical College and York Hospital; at *York, Thursday, January 16, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Coagulation and Obstetrics—When the Blood Clots and When it Doesn't Clot;** by Jefferson Medical College and York Hospital; at *York, Thursday, February 13, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Abortion and Labor Problems Related to Uterine Anomalies;** by Harrisburg Hospital, *Harrisburg, Thursday, February 27, 1969*; 10:30 a.m. Contact W. Smith, M.D., Medical Director, Harrisburg Hospital, S. Front St., Harrisburg 17101.

○ **CPC and Evaluation of the Amenorrheic Patient;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, March 17, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Use and Abuse of Drugs in Pregnancy;** Harrisburg Hospital, *Harrisburg, Thursday, April 24, 1969*; 10:30 a.m.; Contact: W. Smith, M.D., Medical Director, Harrisburg Hospital, S. Front St., Harrisburg 17101.

○ **The High Risk of Pregnancy;** by Jefferson Medical College and Penn State University; at *Allentown Hospital, Thursday, May 8, 1969*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Gynecologic Problems of the Teenager;** by Jefferson Medical College and Penn State University; at *Pottsville Hospital, Thursday, June 12, 1969*; 11:30 a.m. to 2 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

OPHTHALMOLOGY

○ **Twenty-first Annual Clinical Conference;** by Wills Eye Hospital; at Bellevue Stratford Hotel, *Philadelphia, Thursday, February 6-7-8, 1969*. Contact Albert F. Cleveland, M.D., Chairman, Annual Clinical Conference Committee, Wills Eye Hospital, 1601 Spring Garden St., Philadelphia 19130.

PATHOLOGY

○ **Newer Laboratory Methods;** by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, March 3, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Cytogenetics** by Harrisburg Hospital, *Harrisburg, Thursday, March 27, 1969*; 10:30 a.m. Contact: W. Smith, M.D., Harrisburg Hospital, S. Front St., Harrisburg 17101.

PEDIATRICS

○ **Urologic Problems in Children;** by Jefferson Medical College and Penn State University; at *Williamsport Hospital, Wednesday, December 18, 1968*; 11:00 a.m. to 2:30 p.m.; AAGP 3 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Hepatic Metabolism of Drugs;** by Jefferson Medical College and Penn State University; at *Allentown Hospital, Thursday, February 13, 1969*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Heart Murmurs in the Child—The Need for Accurate and Prompt Diagnosis;** by Jefferson Medical College and York Hospital; at *York, Thursday, February 27, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **The Family Doctor, The Pediatrician, and Surgical Care of Children;** at *York, Thursday, April 3, 1969*. (See Surgery for complete information).

○ **Practical Pediatric Diagnosis;** by St. Christopher's Hospital for Children, at *Philadelphia, Tuesday, May 13-16, 1969*; fee \$100; maximum number permitted 100. Contact John B. Bartram, M.D., St. Christopher's Hospital for Children, 2600 North Lawrence St., Philadelphia 19144.

PHARMACOLOGY

○ **Thyrocaltitonin;** by Jefferson Medical College and Penn State University; at *Allentown Hospital, Thursday, December 12, 1968*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

PHYSICAL MEDICINE & REHABILITATION

○ **Current Concepts of Rehabilitation for the Practitioner** by Albert Einstein Medical Center, *Philadelphia, January 15-February 19, 1969*. Fee \$60.00, AA-

GP Credit 18 hours. Contact: Dr. Solomon S. Mintz, Albert Einstein Medical Center, York & Tabor Roads, Philadelphia, Pa. 19141.

PSYCHIATRY

○ **Physician-Community Psychiatrist Seminar;** by Mental Health Guidance Clinic of Butler County, at *Y.W.C.A., 120 West Cunningham St., Butler, 4th Friday of each month, September through June*; AAGP credit, hour for hour; maximum number permitted 20. Contact Robert L. Eisler, M.D., Mental Health Guidance Clinic of Butler County, 128 South Main St., Butler 16001.

○ **Case-oriented Seminars on Psychiatry in Medical Practice;** by Staunton Clinic; at *Pittsburgh, Thursday, January 2 to April 3, 1969 and Wednesday, January 8 to April 9, 1969*; fee \$100. Contact Charlotte M. Florine, M.D., Staunton Clinic, 3601 Fifth Ave., Pittsburgh 15213.

Psychiatry in Medical Practice—Advanced; by Hahnemann Medical College and Hospital, at *Cherry Hill, N. J., Wednesday, January 15-March 19, 1969*; 3:00 p.m.-5:00 p.m. Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Psychiatry in Medical Practice** by Jefferson Medical College, at John E. Davis Community Mental Health Center, 1127 Walnut Street, Philadelphia, *Wednesday, January 15, 1969-April 23, 1969*. Fee: \$35.00, AMA accredited institution. Total course hours: 30, 2 hrs. per day, one day per week, fifteen weeks. Contact: Paul J. Poinard, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

○ **Psychiatry in Medical Practice;** at Jefferson Medical College, *Philadelphia, Thursday, January 16-April 23, 1969*; fee \$35. Maximum number 12. Contact Paul J. Poinard, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Psychiatry for the Non-Psychiatrist;** by Jefferson Medical College and Penn State University; at *Altoona Hospital, Saturday, January 18, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Psychiatry and General Practice;** by Albert Einstein Medical Center; at *Philadelphia, Wednesday, January 22-April 30, 1969*; AAGP 45 hours; minimum number required 7, maximum permitted 20; fee \$75. Contact Solomon Mintz, Albert Einstein Medical Center, York and Tabor Roads, Philadelphia 19141.

○ **The Psychology of the Female;** by Hahnemann Medical College and Hospi-

tal of *Philadelphia, Wednesday, January 22-March 12, 1969*. Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Advanced Psychiatry in Medical Practice**; by Hahnemann Medical College & Hospital at *Philadelphia, Wednesdays, February 26, 1969-April 30, 1969*, 1:30-3:30 p.m., *Thursdays, February 26, 1969*, 1:30 p.m.-3:30 p.m. Fee: \$50.00. AMA accredited institution. Contact: Paul Jay Fink, M.D., Postgraduate Psychiatry Director, Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Family Therapy**; by The Institute of the Pennsylvania Hospital, at *Philadelphia, Wednesday, March 5-May 21, 1969*; fee \$50; minimum number required 10, maximum permitted 15. Contact Sydney E. Pulver, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia 19139.

○ **Basic Psychiatry in Medical Practice**; by Hahnemann Medical College & Hospital at *Philadelphia, March 6, 1969-May 8, 1969*. Fee \$50.00. AMA accredited institution. Contact: Paul Jay Fink, M.D., 230 North Broad St., Philadelphia 19102.

○ **Problems in Communication and Collaboration between Psychiatrists and Other Physicians, 8th Colloquium for Postgraduate Techniques of Psychiatry**, Hilton Hotel, *Pittsburgh, March 22 & 23, 1969*. Contact: Rex A. Pittenger, M.D., 369 Sunset Road, Pittsburgh 15237.

○ **Psychiatry and the Internist**; by Hahnemann Medical College and Hospital; at Host Farm Resort Motel, *Lancaster, Monday, March 31-April 2, 1969*; fee \$100; minimum required 100, maximum permitted 500. Contact Paul Jay Fink, M.D., Hahnemann Medical College, 230 North Broad St., Philadelphia 19102.

○ **Psychiatric Problems of the Middle Aged Woman**; by Jefferson Medical College and Penn State University; at *Allentown Hospital, Thursday, April 10, 1969*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Somatic Manifestations of Psychiatric Disease—As Seen in the Office**; by Jefferson Medical College and York Hospital, at *York, Thursday, April 24, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

RADIOLOGY & RADIOISOTOPES

○ **Symposia on Advances on Radiology; Diagnosis and Treatment**; by Jefferson Medical College and Penn State University; at Mercy Hospital, *Scranton,*

Wednesday, March 19, 1969; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

SURGERY

○ **Cleft Palates and Other Oral or Pharyngeal Abnormalities in Infants—Their Approach and Repair**; by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, December 19, 1968*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **The Hand**; by University of Pennsylvania, School of Medicine, Division of Graduate Medicine; at *Philadelphia, Monday, January 20-31, 1969*; fee \$150. Maximum permitted—50 the first week, 150 the second week. Contact Paul Nemir, Jr., M.D., Division of Graduate Medicine, University of Pennsylvania, 237 Med. Labs., 36th & Hamilton Walk, Philadelphia 19104.

○ **The Challenge of Surgery—Pre and Postoperative Care of the Patient**; by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, January 30, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **The Surgery of Peptic Ulcer Disease**; by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, February 6, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **The Gallbladder Revisited—A Review of Recent Concepts of the Diagnosis and Treatment of Gallbladder Disease; (including a five-patient case study)**; by Jefferson Medical College and York Hospital; at *York Hospital, Thursday, March 20, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Two day visit—March 19 and 20. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **M/M and Treatment of Burns**; by Jefferson Medical College and Penn State University; at Crozer-Chester Medical Center, *Chester, Monday, March 24, 1969*; 2:00 to 5:00 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **The Family Doctor, The Pediatrician, and Surgical Care of Children—The Special Needs of the Age Group**; by Jefferson Medical College and York Hos-

pital; at *York Hospital, Thursday, April 3, 1969*; fee \$50 for 112 hour, 28 day Continuing Seminars in Medical Education; AAGP credit 100 hours. Contact Robert L. Evans, M.D., York Hospital, 1001 South George St., York 17403.

○ **Surgical Diseases of the Gastrointestinal Tract**; by Division of Graduate Medicine, School of Medicine, University of Pennsylvania; at Graduate Hospital of the University of Pennsylvania, *Philadelphia, Monday, April 7-18, 1969*; fee \$200; minimum required 20, maximum permitted 75. Contact Paul Nemir, Jr., M.D., Director, Division of Graduate Medicine, 237 Medical Laboratories, Philadelphia 19104.

○ **Recognition and Management of Surgical Shock**; by Jefferson Medical College and Penn State University; at Conemaugh Valley Memorial Hospital, *Johnstown, Tuesday, April 22, 1969*; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

UROLOGY

○ **The Most Commonly Misdiagnosed Genitourinary Problem; Namely, Acute Urinary Tract Infection**; by Harrisburg Hospital, *Harrisburg, Tuesday, January 14, 1969*; 5:00 p.m. Contact W. Smith, M.D., Medical Director, Harrisburg Hospital, S. Front St., Harrisburg 17101.

GENERAL

○ **Nuclear Medicine Today**; by Jefferson Medical College and Penn State University; at *Altoona Hospital, Thursday, March 20, 1969*; 8:45 a.m. to 12:30 p.m.; AAGP 2 hours. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Symposia on Principles of Interviewing**; by Jefferson Medical College and Penn State University; at Mercy Hospital, *Scranton, Wednesday, April 2, 1969*; AAGP 3 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Old Tool—New Uses: The Patient's Chart in Medical Education**; by Jefferson Medical College and Penn State University; at Conemaugh Valley Memorial Hospital, *Johnstown, Tuesday, May 27, 1969*; AAGP 2 hours; no fee. Contact John H. Killough, M.D., Jefferson Medical College, 1025 Walnut St., Philadelphia 19107.

○ **Scientific Advancement in Harrisburg Hospital, Attendant upon the Building Program**; *Harrisburg, Thursday, June 5, 1969*; 5:00 p.m. Contact W. Smith, M.D., Medical Director, Harrisburg Hospital, S. Front St., Harrisburg 17101.

RADIO SEMINARS IN MEDICINE

On FM Radio at Noon:

Philadelphia: WUHY (90.0 mc) Tuesdays and Thursdays

Pottsville: WPPA (101.9 mc) Thursdays

Harrisburg: WHP (97.3 mc) Thursdays.

○ **Today's Treatment of Chronic Renal Failure**, Lee Henderson, M.D., Asst. Professor of Medicine, University of Pennsylvania School of Medicine; Director, Dialysis Unit, and Co-director, Transplantation Unit, Hospital of the University of Pennsylvania, *December 10 and 12, 1968.*

○ **Tuberculosis, Histoplasmosis and Related Pathogens**, Robert Maycock, M.D., Associate Professor of Clinical Medicine, University of Pennsylvania School of Medicine; Chief of the Pulmonary Section, Hospital of the University of Pennsylvania and Philadelphia General Hospital, *December 17 and 19, 1968.*

○ **Selective Management of Hypertension**, Robert J. Gill, M.D., Associate Physician, Pennsylvania Hospital and Assistant Professor of Clinical Medicine, University of Pennsylvania School of Medicine, *January 7 and 9, 1969.*

○ **Diagnostic Possibilities by X-Ray**, William Tuddenham, M.D., Director, Department of Radiology, Pennsylvania Hospital and Professor of Radiology, University of Pennsylvania School of Medicine, *January 14 and 16, 1969.*

○ **Guides to Treatment of Anemias**, Roger Daniels, M.D., Assistant Physician, Pennsylvania Hospital and Presbyterian

Hospital; Associate in Medicine, University of Pennsylvania School of Medicine, *January 21 and 23, 1969.*

○ **Control of Symptoms in Allergy**, Leonard Parkhurst, M.D., Consulting Physician in Medicine and Allergy, Pennsylvania Hospital and Consultant in Allergy, Delaware County Memorial Hospital, *January 28 and 30, 1969.*

○ **Selection of Antibiotics**, Robert Wise, M.D., Magee Professor of Medicine and Head of the Department of Medicine, Jefferson Medical College, Philadelphia, *February 4 and 6, 1969.*

○ **The Forgotten Liver**, Dhodanand Kowlessar, M.D., Professor of Medicine, Director, Division of Gastroenterology and Director of the Clinical Research Center, Jefferson Medical College, Philadelphia, *February 11 and 13, 1969.*

○ **Upper Gastrointestinal Ulcerative Disease**, Edward Raffensberger, M.D., Associate Professor of Medicine, University of Pennsylvania School of Medicine and Gastroenterologist, Hospital of the University of Pennsylvania, *February 18 and 20, 1969.*

○ **Non-Bacterial Pneumonias**, Hobart Reimann, M.D., Professor of Medicine, Hahnemann Medical College & Hospital, Philadelphia, *February 25 and 27, 1969.*

○ **Significance of Venereal Symptomatology**, Paul Gross, M.D., Chief, Section of Dermatology, Pennsylvania Hospital and Associate in Dermatology, University of Pennsylvania School of Medicine, *March 4 and 6, 1969.*

○ **Practical Pediatrics**, Robert A. Schless, M.D., Consultant in Pediatrics to

the Albert Einstein Medical Center, Philadelphia, *March 11 and 13, 1969.*

○ **Meeting the Cardiac Emergency**, Norman Makous, M.D., Associate Physician and Associate Cardiologist, Pennsylvania Hospital and Associate in Medicine, University of Pennsylvania School of Medicine, *March 18 and 20, 1969.*

○ **Fits, Faints and Funny Turns**, Richard Masland, M.D., Associate Professor of Neurology and Physiology, University of Pennsylvania School of Medicine, *March 25 and 27, 1969.*

○ **Genetic Diseases**, William Mellman, M.D., Associate Professor of Pediatrics and Medical Genetics, University of Pennsylvania School of Medicine, *April 1 and 3, 1969.*

○ **Thyroid Problems**, George Ross Fisher, M.D., Asst. Professor of Clinical Medicine, Jefferson Medical College, Philadelphia, *April 8 and 10, 1969.*

Summaries available from:

Guy Lacy Schless, M.D.
Pennsylvania Hospital Continuation Education Program
c/o Pennsylvania Hospital
Eighth and Spruce Streets
Philadelphia, Pa. 19107

TELEVISION

On Television at Noon each Monday, Pittsburgh: UHF Channel 16.

Medical subjects announced each week by mail to 65 participating hospitals.

University of Pittsburgh, School of Medicine, Postgraduate Programs, Pittsburgh, Pa. 15213.



Psychiatric Residencies

Pennsylvania Hospital with outstanding teaching, therapy, research, and residencies programs and large medical staff offer fully accredited three-year training to physicians desiring certification: residencies include individual supervision of psychotherapy, experience on adolescent wards, and with patient therapy of children, college students, and adults; programs supplemented by regularly scheduled guest lecturers and three months intensive graduate lecture course at Eastern Pennsylvania Psychiatric Institute; excellent salary levels. GP Grants available; residencies beginning in January and July.

Also

Immediately available in newly constructed \$9 million "Institute for Geriatric Research" positions for Internists interested in research and General Practitioners interested in this field. Pennsylvania License necessary; excellent salary plus additional benefits.

Fringe Benefits

Liberal fringe benefits include 15 paid vacation days, 13 paid legal holidays, 15 paid sick leave days per annum; excellent retirement program; annual opportunity for meritorious salary increment; maintenance and housing available. Qualified candidates write: Superintendent, Warren State Hospital, Box 240, Warren, Pa. 16365, for details.

PMS | OFFICIALLY ENDORSED

DISABILITY INSURANCE PROGRAMS

ACCIDENT AND HEALTH PROTECTION

Indemnities up to \$250.00 per week. Long term sickness and lifetime accident protections available. Daily hospital benefits and surgical protection available for both members and dependents. Selection of waiting periods. Conversion plans available at age 70.

MAJOR HOSPITAL EXPENSE PROTECTION

\$7,500 Maximum Benefits after \$500 deductible for both members and dependents.
This protection may be retained *for life!*

HIGH LIMIT ACCIDENTAL DEATH, DISMEMBERMENT AND PERMANENT TOTAL DISABILITY

Maximum limit \$150,000 members; \$75,000 wife of member. New low cost of \$.85 per thousand per year. Full principal sum paid for permanent and total disability from bodily injury.

• BERTHOLON-ROWLAND AGENCIES •

WESTERN PENNSYLVANIA

Dexter Bertholon-Rowland, Inc.

1518 Frick Building, Pittsburgh, Pa. 15219
471-9552
(area code 412)

EASTERN PENNSYLVANIA

Bertholon-Rowland, Inc.

Public Ledger Bldg., Philadelphia, Pa. 19106
WAlnut 5-7045
(area code 215)

★ THE MAN WHO PLANS AHEAD INSURES WHILE HE IS INSURABLE ★

in the treatment of IMPOTENCE



Android[®]

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY ANDROID

GOOD TO EXCELLENT 75%

PLACEBO

20%

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS - Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . . 10 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily
Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . . 5.0 mg.
Thyroid Ext. (1/2 gr.) . . . 30 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus

WITH HIGH POTENCY

B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/4 gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . . . 250 mg.
Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate . . . 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN

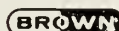
Android-E

Each Tablet Contains:

Methyl Testosterone 2.5 mg.
Ethynyl Estradiol 0.02 mg.
Thyroid Ext. (1/6 gr.) 10 mg.
Thiamine Hydrochloride 10 mg.
Glutamic Acid 50 mg.

INDICATIONS Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen - only steroid effect remains. Geriatrics, postoperative and debilitating disease, osteoporosis. **DOSE** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens, hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRAINDICATIONS:** See Android. Ethynyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:



THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

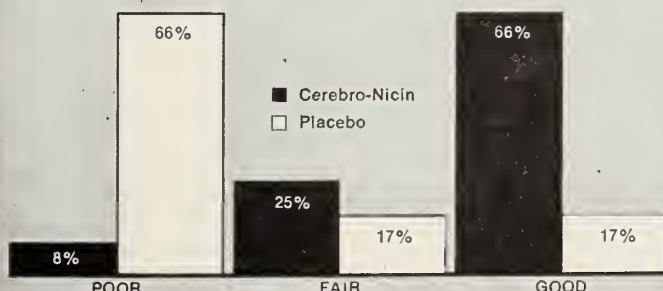


For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin[®] capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN[®] New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jr., of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
1-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine 3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

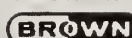
AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

Write for literature and samples...



THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

Write for Product Catalog





○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Adolphus Koenig, Glenshaw;** University of Pittsburgh School of Medicine, 1921; age 72; died Sept. 24, 1968. He is survived by his wife, one son and three daughters.

○ **Herman B. Popky, Scranton;** Temple University School of Medicine, 1931; age 63; died September 23, 1968. He was a medical officer in World War II, and a member of the American Board of Radiology, the American Roengen Ray Society and the North American Radiological Society. Dr. Popky is survived by his wife, a son, George Popky, M.D., Philadelphia, a daughter, a sister and a brother.

○ **Ira M. Henderson, Fairfield;** Jefferson Medical College, 1917; age 79; died September 19, 1968. He had been a physician in Fairfield for over 50 years. Surviving are his wife and daughter.

○ **Theodore W. Battafarano, Philadelphia;** Hahnemann Medical College, 1929; age 63; died September 12, 1968. He had taught at Hahnemann Medical College and was a member of the American Diabetic Society. He is survived by his wife.

○ **Frank Louis DaParma, Pittsburgh;** Georgetown Medical School, 1936; age 57; died September 9, 1968. He served in the Army Medical Corps in World War II. Surviving are his wife and son.

○ **Kenneth Mosier Day, Pittsburgh;** Johns Hopkins University School of Medicine, 1921; age 72; died September 9, 1968. He had founded and served as executive director of the audiology department at Eye and Ear Hospital and was professor of otology at the University of Pittsburgh School of Medicine until 1963. He has served as president of the American Otological Society, the Pittsburgh Academy of Medicine, and the medical staff of Eye and Ear Hospital. Surviving are his wife, a daughter and a brother.

○ **Mary R. H. Lewis, Philadelphia;** Women's Medical College, 1911; age 89; died September 19, 1968. Dr. Lewis was a pioneer woman physician, and had served as director of the West Philadelphia College for Women.

She was a past president of the Philadelphia County Medical Society and the American Women's Medical Association. Surviving is a brother.

○ **George A. Poe, Fayetteville;** Ohio State University College of Medicine, 1918; age 75; died September 9, 1968. He was a fellow of the American College of Chest Physicians and was head of the tuberculosis clinic at Chambersburg Hospital at the time of his death. He is survived by his wife, a daughter and two sisters.

○ **John M. Trapnell, Jr., Philadelphia;** West Virginia University School of Medicine, 1941; age 52; died September 15, 1968. He is survived by his wife, two sons and a sister.

○ **David Weisberg, Pittsburgh;** University of Pennsylvania School of Medicine, 1930; age 63; died September 12, 1968. He is survived by his wife and two daughters.

○ **William Robert Brewer, Altoona;** Hahnemann Medical College, 1923; age 71; died September 26, 1968. He was a member of the Pennsylvania Academy of Ophthalmology and Otolaryngology. Surviving is his wife.

○ **Louis N. Carideo, Philadelphia;** St. Louis University School of Medicine, 1943; age 51; died October 1, 1968. He was police and fire surgeon. Surviving are his wife, two sons, a brother, and two sisters.

○ **Francis H. Eaton, Philadelphia;** University of Pennsylvania School of Medicine, 1919; age 74; died September 23, 1968. He had been professor of obstetrics and gynecology at University of Pennsylvania School of Medicine. Surviving are his wife, a son, Edward H. Eaton, M.D., and a daughter.

○ **W. Benson Harer, Upper Darby;** University of Pennsylvania School of Medicine; age 71; October 11, 1968. Dr. Harer was a past president of the Pennsylvania Medical Society and was emeritus professor of clinical obstetrics and gynecology at the University of Pennsylvania School of Medicine. He was a member of the Governor's Hospital Study Commission. He is survived by his wife, a son, W. Benson Harer, Jr., M.D., a daughter, and a brother.

○ **Harry Miller Forbes, Chester;** Temple University School of Medicine, 1935; age 62; died September 30, 1968. Dr. Forbes was a fellow of the American College of Surgeons and a member of the Pennsylvania Orthopedic Society. He became ill while attending the annual session of PMS in Pittsburgh. He is survived by his wife, three children, a brother and a sister.

○ **George B. Faries, Selinsgrove;** Jefferson Medical College, 1924; age 69; died October 15, 1968. He served five years in the Army during World War II. He is survived by his wife, a son, George B. Faries, M.D., Camp Hill, two daughters, three brothers, one of whom is Randolph Faries, M.D., Philadelphia, and three sisters.

○ **Albert Goldblum, Pittsburgh;** University of Pittsburgh School of Medicine, 1930, age 61; died September 26, 1968. He was a member of the American Academy of Dermatology. Survivors include his wife, two sons, his mother, three sisters, and three brothers who also are doctors. They are: Jacob Goldblum, M.D., Raymond W. Goldblum, M.D., and Abraham D. Goldblum, M.D.

○ **Alonzo W. Hart, Philadelphia,** Jefferson Medical College, 1934; age 60; died September 27, 1968. He was an Air Force veteran of World War II and a member of the American Heart Association. He is survived by his mother, two sons, two daughters and a sister.

○ **John D. Helm, New Providence;** University of Pennsylvania School of Medicine, 1913; age 81; died September 18, 1968. He practiced medicine in his home town for 55 years. He is survived by his wife, a daughter, a sister, and two sons, Robert C. Helm, M.D., Quarryville, and John D. Helm, Jr., M.D., Lancaster.

○ **Howard C. McMillan, Wooster, Ohio;** Chicago College of Medicine and Surgery, age 91; September 30, 1968. Until his retirement last January, Dr. McMillan was the oldest practicing physician in the country, and had practiced for fifty-nine years, forty-two of them in Aliquippa. He was a past president of the Beaver County Medical Society. He is survived by his wife, two daughters, and two sons, Bruce McMillan, M.D., Pittsburgh, and Howard C. McMillan, Jr., M.D., Wooster, O.



because relief means so much to your G.U. patient

There are not many drug combinations in use today which can claim to have served the medical profession for more than 50 years. Such a record reflects the continued confidence of physicians in URISED. This is not a dramatic "wonder drug" — but a useful one.

URISED is safe . . . especially useful in long-term management of chronic cases; as a prophylactic measure with catheterization or after instrumentation. No systemic reactions or bacterial resistance have been reported.

URISED rapidly exerts spasmolytic action, relieving pain and discomfort of urgency, frequency, and burning on urination. Rapid acting URISED exerts antibacterial action against uropathogens susceptible to methenamine and methylene blue, in an acid medium.

URISED

® Each blue-coated tablet contains active:

Atropine Sulfate . . . 0.03 mg.	Methylene Blue . . . 5.4 mg.
Hyoscyamine . . . 0.03 mg.	Phenyl Salicylate . 18.1 mg.
Methenamine . . . 40.8 mg.	Benzoic Acid . . . 4.5 mg.

PRECAUTIONS: Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

SIDE EFFECTS: Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—Initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

Stocked Nationally Through All Service Wholesale Druggists



CONAL
PHARMACEUTICALS, INC.
CHICAGO, ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

• CYSTOSPAZ® • URISEDAMINE® • ŪTRASUL® Tablets and Suspension

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

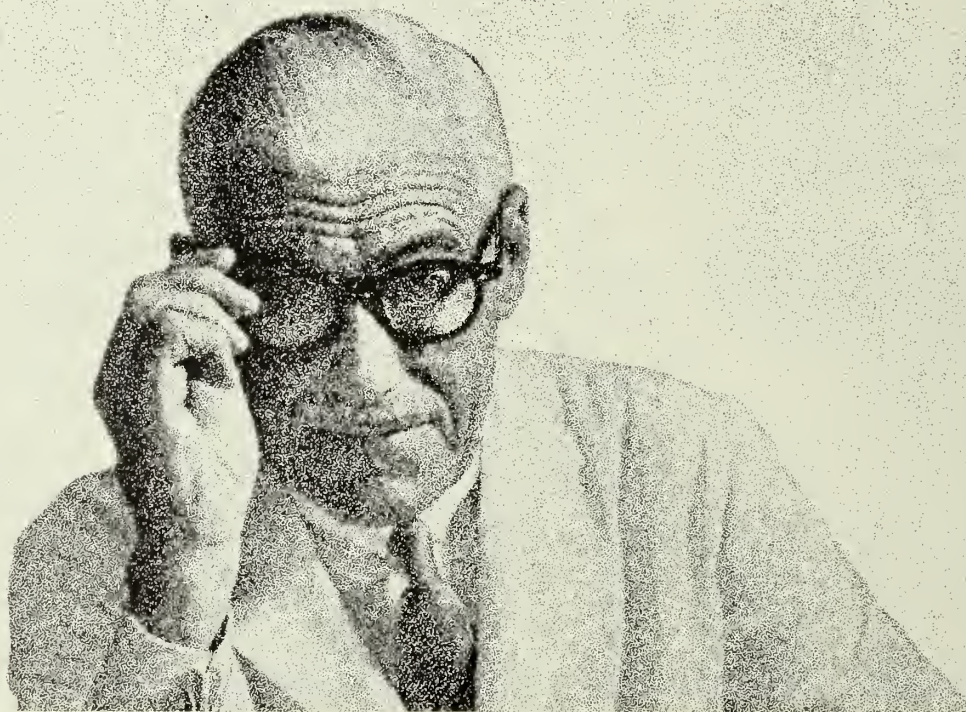
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We are closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society 



PENNSYLVANIA DIVISION

PHILADELPHIA DIVISION

PENNSYLVANIA CANCER FORUM PAGE—presented cooperatively by the Council on Education and Science of the Pennsylvania Medical Society, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health.



PENNSYLVANIA
MEDICINE

write now

Booklets: *A Community Mental Health Approach to Drug Addiction*, from Government Printing Office, Washington, D.C. . . . *Institutionalization of the Mentally Retarded*, National Association for Retarded Children, New York City . . . *Assessment of the Quality of Medical Care, an Annotated Bibliography*, American Rehabilitation Foundation, Minneapolis . . . *Selected References on Group Practice*, Government Printing Office, Washington, D.C. . . . *Cosmetic Surgery, What it Can and Cannot Do*, Committee on Cutaneous Health and Cosmetics, AMA, 535 N. Dearborn St., Chicago, Ill. 60610 . . . *Health Quackery, —Arthritis, Health Quackery, Devices, Health Quackery, Chiropractic*, 20¢ for each booklet, from AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

Pamphlets: *A Guide for Medical Evaluation of Candidates for School Sports*, 25¢ from AMA Committee on Medical Aspects of Sports, 535 N. Dearborn St., Chicago, Ill. 60610 . . . *Tetanus, the Second Deadliest Poison*, 15¢ from AMA, 535 N. Dearborn St., Chicago, Ill. 60610 . . . *Immunization, a Priceless Asset*, 10¢ from AMA, 535 N. Dearborn St., Chicago, Ill. 60610 . . . *Diabetes and You*, 25¢ from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402 . . . *Report of the Medical X-Ray Advisory Committee on Public Health Considerations*, 35¢ from Superintendent of Documents, Government Printing Office, Washington, D.C. 20204.

Borrowing a car for a
joyride isn't the biggest
crime in the world.
But it's a start.



DON'T HELP A GOOD BOY GO BAD.
LOCK YOUR CAR. TAKE YOUR KEYS.

Acceptable for 10 Hours AAGP Credit

22nd NATIONAL CONFERENCE ON RURAL HEALTH

**THEME: MEETING RURAL HEALTH NEEDS
IN OUR CHANGING TIMES**

March 21-22, 1969

Philadelphia Marriott Motor Hotel
Philadelphia

Sponsored by: Council on Rural Health,
American Medical Association

Hosted by: Pennsylvania Medical Society

THE PENNSYLVANIA SOCIETY OF COLON AND RECTAL SURGERY

THE ANNUAL ORATION MEETING

Friday, January 10th, 1969

Union League Club of Philadelphia
Broad and Sansom Streets
Philadelphia, Pa.

PROGRAM

MANAGEMENT OF ADENOMATOUS POLYPS OF THE
COLON AND RECTUM

GUEST SPEAKER

Neil W. Swinton, M.D., F.A.C.S.
Head of Department of Colon and Rectal Surgery
Lahey Clinic, Boston, Mass.

Cocktails: 6:30 P.M. Anniversary Dinner: 7:30 P.M.
Dress: Black Tie Preferred Guests are Most Cordially Invited

Frank H. Murray, M.D., Program Chairman,
Harry E. Bacon, M.D., Co-chairman,
Benjamin Haskell, M.D.

Kindly mail check to **Valentine R. Manning, Jr., M.D.**, 3336 Aldine Street, Philadelphia, Penna., for \$12.50 and make payable to the Pennsylvania Society of Colon and Rectal Surgery.

Robert A. McGregory, M.D., Secretary.



ALBERT EINSTEIN MEDICAL CENTER

ANNOUNCES A POSTGRADUATE COURSE IN CURRENT CONCEPTS IN HEMATOLOGIC DISORDERS

ABRAHAM M. FRUMIN, M.D.
Director
At Its

DAROFF DIVISION

on

Wednesday Afternoons

From 2 to 5 P.M.

January 15, 1969 through March 19, 1969

The course will concern itself with recent bio-chemical, immunologic, and radio-active isotope techniques and concepts, which have application to recent advances in various hematologic disorders. Each session will consist of two speakers with a one-hour question and answer period. It's the purpose of the course to acquaint the practicing physician of recent advances in diagnosis and therapy of these disorders.

This course will be given on ten consecutive Wednesdays. The course is acceptable for thirty hours of Credit by the American Academy of General Practice, Category I. Registration closes January 5, 1969.

For brochure and application form, write to
DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION
ALBERT EINSTEIN MEDICAL CENTER
York and Tabor Roads
Philadelphia, Pennsylvania 19141



PENNSYLVANIA
MEDICINE

meetings

DECEMBER

Twenty-seventh Annual Meeting, American Academy of Dermatology, December 7-12, Chicago, Ill.

Susquehanna Valley Regional Medical Program, Dec. 10-11, Board Room, PMS Headquarters, Lemoyne, Pa.

PaMPAC Board Meeting, December 15, Board Room PMS Headquarters, Lemoyne, Pa.

JANUARY

PMS Board Meeting, January 8-9, Board Room, PMS Headquarters, Lemoyne, Pa.

PMS Committee on Mental Health, January 26, Union League, Philadelphia, Pa.

Sixth Annual Postgraduate Seminar, American Society of Anesthesiologists, January 9-12 Miami Beach, Fla.

Annual Meeting, Society for Cryosurgery, January 12-17, Miami Beach, Fla.



ALBERT EINSTEIN MEDICAL CENTER

ANNOUNCES A POSTGRADUATE COURSE IN CURRENT CONCEPTS OF REHABILITATION FOR THE PRACTITIONER

LEONARD D. POLICOFF, M.D.
Director
At Its

NORTHERN DIVISION

MOSS REHABILITATION HOSPITAL

12th and Tabor Roads

on

Wednesday Afternoons From 2 to 5 P.M.

January 15, 1969 through February 19, 1969

In this course an attempt will be made to convey current knowledge and skills which can be utilized by the practitioner in his own practice, in the areas of electrodiagnosis and electromyography, in the rehabilitation of the arthritides, the amputee, and those with chronic neurologic disorders including stroke, musculoskeletal disorders, the chronic pulmonary disorders in the cancer states. Presentation will be both didactic and demonstrative in nature with student participation.

The course will be given on six consecutive Wednesdays. The course is acceptable for eighteen hours of Credit by the American Academy of General Practice Category I. Limited registration of 20 students closes January 2, 1969.

For brochure and application form, write to
DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION
ALBERT EINSTEIN MEDICAL CENTER
York and Tabor Roads
Philadelphia, Pennsylvania 19141



ALBERT EINSTEIN MEDICAL CENTER

ANNOUNCES A POSTGRADUATE COURSE IN PSYCHIATRY AND GENERAL PRACTICE

BERNARD COWITZ, M.D.
Director
At Its

NORTHERN DIVISION

on

Wednesday Afternoons From 1:30 to 4:30 P.M.

January 22, 1969 through April 30, 1969

This course is designed to review the practical aspects of diagnosis and office management of the common psychiatric problems encountered by the general practitioner. Many of the presentations will be with patient material. Like interviews, one-way screen and closed circuit television will be utilized. These interviews will serve to demonstrate techniques of interviewing, psychiatric symptomatology, and psychotherapy. The subject matter will be presented primarily in seminar form to encourage interchange of thought and active participation of all class members. In fact, the registrants will be encouraged to present problem cases from their own practice for general discussion. The various modalities of treatment will be discussed with special emphasis on "short term" therapy which can be utilized daily in practice. The psychotropic drugs will be thoroughly reviewed from the standpoint of their pharmacology, indication and untoward reactions.

This course will be given on fifteen consecutive Wednesdays. The course is acceptable for forty-five hours of Credit by the American Academy of General Practice Category I. Limited registration of 20 students will close January 6, 1969.

For brochure and application form, write to
DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION
ALBERT EINSTEIN MEDICAL CENTER
York and Tabor Roads
Philadelphia, Pennsylvania 19141

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

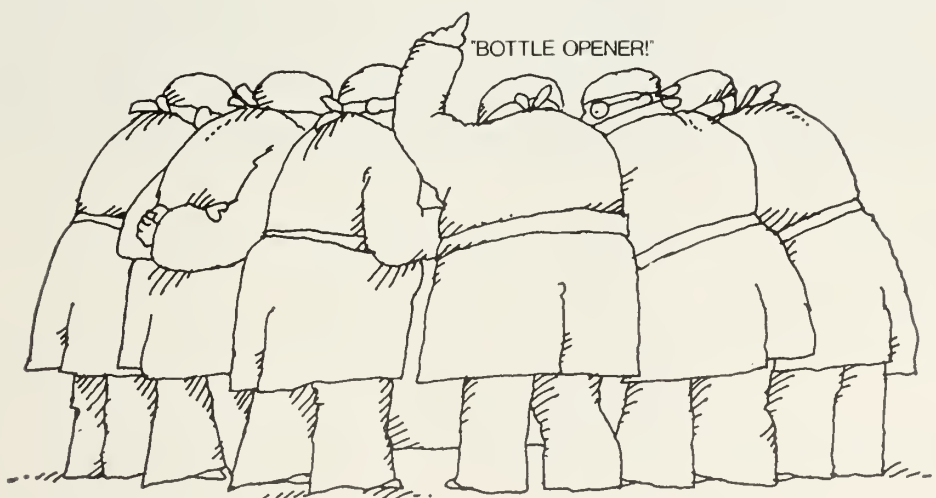
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-253-2761



"COKE HAS THE TASTE YOU NEVER GET TIRED OF."



COCA-COLA AND "COKE" ARE REGISTERED TRADE MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY



PHYSICIAN WANTED

General Practitioner or internist needed in attractive, friendly, rural, non-farm upstate New York area, population 6,200. New office space available soon. Nearest hospital, urban area, fifteen miles. Excellent schools, good place to raise children. Write MRS. HAROLD BARTZ, R.D. #1, Newark Valley, N. Y. 13811, or call (607) 642-3661.

Anesthesiologist, Board certified or eligible, for 535-bed general hospital ideally located in medium-sized urban Pennsylvania community. Staff consists of four anesthesiologists, 12 CRNA's, plus students in School of Nurse Anesthetists. Salary plus fee for service, one month off for vacation and meetings, other liberal fringe benefits. Write Department 540, PENNSYLVANIA MEDICINE.

Associate radiologist needed. Rapidly growing 320-bed hospital seeks associate for x-ray department just completed. Modern diagnostic, therapy and isotope departments. Salary or percentage as desired. College town—Penn Hall, Wilson College. New junior high school; new vocational school under construction; community college planned. Write in confidence to F. J. O'BRIEN, Administrator, Chambersburg Hospital, Chambersburg, Pa. 17201.

Rotating Internship: 266-bed general hospital, center city Philadelphia, offers ten rotating internships. Active affiliation with university medical center, full-time directors of education in medicine and surgery. Monthly stipend \$525, married, and \$500, single, plus partial maintenance. Apply Department 539, PENNSYLVANIA MEDICINE.

Psychiatrist for expanding psychiatric services at Elwyn Institute located in

suburban Philadelphia. Elwyn offers a comprehensive range of services for the emotionally disturbed and mentally retarded child and adult. University and medical school affiliations with opportunities for research and training. Salary commensurate with training and experience. Liberal retirement insurance, vacation and other benefits. Contact GERALD R. CLARK, M.D., Elwyn Institute, Elwyn, Pa. 19063.

Internist or general practitioner for association/partnership with established GP. Salary first year. Office next to modern, well-equipped, accredited, 140-bed general hospital. Full-time hospital-based anesthesiologist, radiologist, pathologist. Excellent working conditions with immediate hospital privileges. Progressive community in southwestern Pennsylvania on Pennsylvania Turnpike. One hour from Pittsburgh Medical Center. Excellent school system. Excellent recreation facilities, winter and summer. Write Dept. 536, PENNSYLVANIA MEDICINE.

House physician for 202-bed general hospital, located in a growing university community, 55 miles from Pittsburgh. Rotate services with other house physicians. Pennsylvania license required. An excellent introduction to a community with good practice opportunities. Contact ADMINISTRATOR, Indiana Hospital, Indiana, Pa. 15701.

Psychiatric residency training—two year approved, third year in University connected Psychiatric Institute. \$8,580 to \$12,075; maintenance arrangements possible. ECFMG and/or license acceptable in Pennsylvania required. R. L. GATSKI, M.D., Superintendent, Danville State Hospital, Danville, Pa. 17821.

Anesthesiologist—Board eligible or certified. Developing department in expanding 185-bed specialty hospital of University Health Center group. Teaching and research opportunities. Salary negotiable. Call or write: J. R. QUINN, M.D., Eye and Ear Hospital, Pittsburgh, Pa. 15213.

Anesthesiologist, Board certified or eligible, to join six-man partnership in 430-bed hospital in Bryn Mawr. Liberal salary first year, partnership following. Write Department 538, PENNSYLVANIA MEDICINE.

Emergency Room physician, general practitioner, wanted for established group. Excellent guarantee and percentage. 42-hour average. City of 30,000 near Hershey Medical Center. Contact EMERGENCY OUTPATIENT ASSOCIATES, Good Samaritan Hospital, Lebanon, Pa. 17042. Telephone (717) 272-7611, Ext. 283.

Internists, general practitioners, pediatricians wanted for group medical practice in inner-city Philadelphia. Prefer those interested in social change. Competitive salary, fringe benefits and faculty appointments to medical school for qualified physicians. Please contact DR. JOHN FLANAGAN, 2539 Germantown Ave., Philadelphia, Penna. 19133.

Emergency Room physicians needed for full-time staffing. Ideal for the new graduate or for the experienced physician wishing to slow down. Write ADMINISTRATOR, Sharon General Hospital, Sharon, Pa.

Wanted: Two radiologists for progressive x-ray department in a 325-bed general hospital in western Pennsylvania. Equipment excellent, including 2 remote TV units. At least one applicant must be board certified. Many fine strictly residential areas within 10 minutes of hospital. Relations with administration excellent. All compensation negotiable. Personal interviews required. Need is immediate, but can await previous commitments. Send resume to Department 532, PENNSYLVANIA MEDICINE.

Physicians—Part or full time. Student and employee health service. Medical School hospital affiliation. Faculty

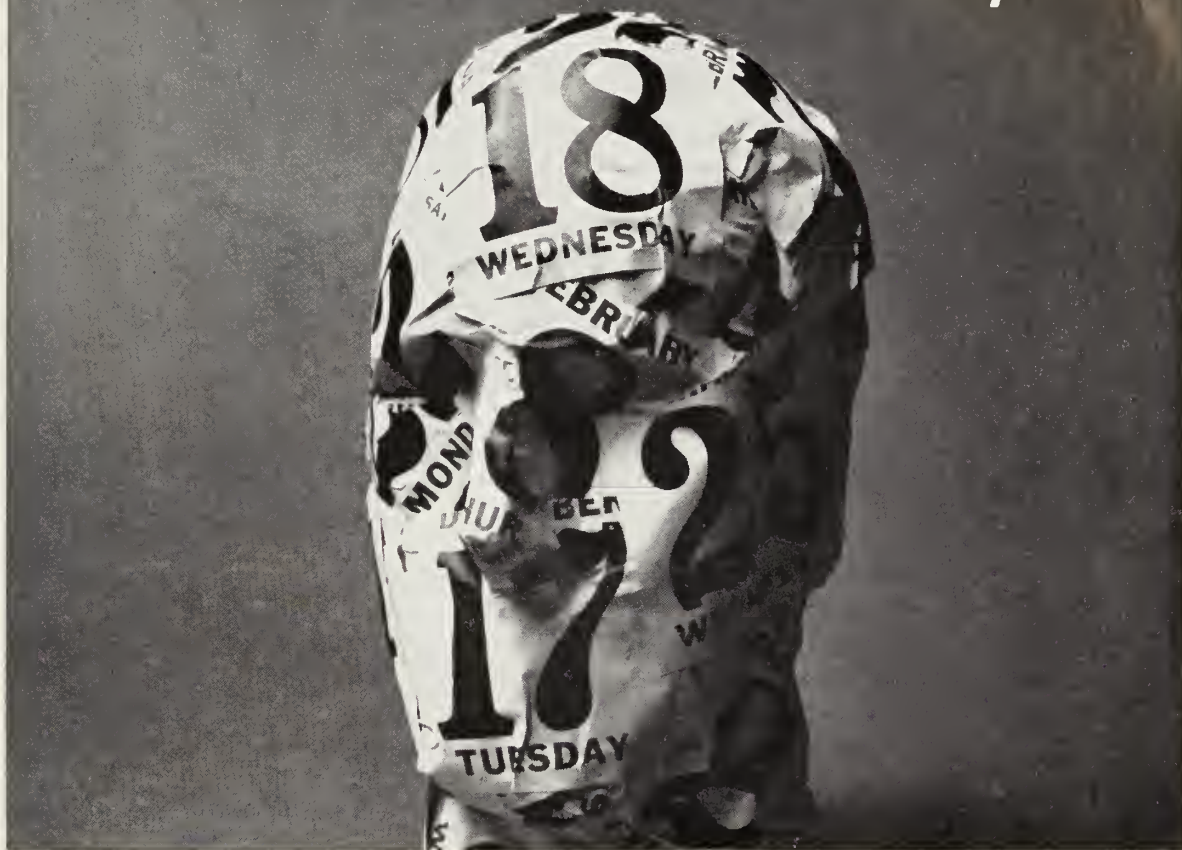
(Continued on page 75.)



Someone you know needs



Most "head colds" last 7 to 14 days



In the meantime... Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I¹³¹ uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Spansule® capsules brand of sustained release capsules



Smith Kline & French Laboratories

*Easy on
the Budget...*

*Easy on
the Mother*

*Tablets & Elixir
For Iron Deficiency Anemia*



BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS
Fergon[®]
brand of FERROUS GLUCONATE



Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

1913

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

EASTERN PENNSYLVANIA OFFICE:

E. L. Edwards, D. R. Lowe, L. R. Wilson, Jr., and S. B. Elston, Jr., Representatives
Suite 126-BC, The Benson, Jenkintown 19046 Telephone: 215-887-6335

WESTERN PENNSYLVANIA OFFICE: N. Wells and S. T. Ingram, Representatives
1074 Greentree Road, Pittsburgh 15220 Telephone: 412-531-4226

classified

appointment. Salary commensurate with qualifications. Submit curriculum vitae. Z-29, P. O. Box 2069, Philadelphia, Pa. 19103. An equal opportunity employer.

General Practitioners: We Need You. Beautiful, progressive community of Zelienople, located just 30 minutes north of Pittsburgh. Market area of 10,000. Excellent facilities, Assistance available. T. R. MURRAY, Zelienople Area Jaycees, Box 35, Zelienople 16063.

Psychiatrist or physician—accredited hospital. Approved psychiatric residency program, affiliated with approved general hospital. \$14,657 to \$22,768; maintenance arrangements possible. Pennsylvania license required. R. L. GATSKI, M.D., Superintendent, State Hospital, Danville, Pa.

Small general hospital in North Central Philadelphia is reorganizing the medical staff. There are openings for staff membership in departments of medicine and surgery and some chiefships of clinical services. Requirements: graduate of an approved school of medicine and licensed in Pennsylvania. Write Dept. 535, PENNSYLVANIA MEDICINE.

Needed—Staff physicians, internists and generalists: JCAH fully accredited ultra-modern 2000-bed chronic disease hospital (no psychotic or tuberculous patients); dynamic rehabilitation program; university affiliations; regular consultation available in all specialties; five day thirty-five hour work week; liberal paid vacations and holidays;

pension plan; insurance and other fringe benefits; limited number of ranch type homes and apartments available on the premises; Pennsylvania license required; salary competitive and negotiable. Contact G. P. HAMMILL, M.D., John J. Kane Hospital, Pittsburgh, Pa. 15243.

Psychiatric Residencies—Pennsylvania hospital with outstanding teaching, therapy and research programs and large medical staff offers fully accredited three-year training to physicians desiring certification: residency includes individual supervision of psychotherapy, experience on adolescent wards and out patient therapy of children, college students and adults; program supplemented by regular scheduled guest lecturers and three-month intensive graduate lecture course at Eastern Pennsylvania Psychiatric Institute. Excellent salary plus additional benefits. G. P. grants available; residencies begin January and July. Write: WARREN STATE HOSPITAL, Box 249, Warren, Pa. 16365 for details.

PRACTICES AVAILABLE

General Practice for sale, including home and office. Forced to sell due to disability and old age. Practice in the city of Lebanon, with a population of 50,000; two hospitals; and Bethlehem Steel Corporation plant. Practiced here 64 years. Contact CLYDE J. SAYLOR, M.D., 368 N. Eighth St., Lebanon.

General practice in Southwestern Pennsylvania; three and one-half-acre estate; four-bedroom home; five-room new electric office and equipment. Open staff hospital. Will sacrifice \$45,000. Leaving to specialize. Write Department 537, PENNSYLVANIA MEDICINE.

Lucrative, established general medical practice in Southeastern Pennsylvania, with 15-room, 4½-bath residence and air-conditioned offices. Near many hospitals, excellent schools. Thirty-five miles to center Philadelphia. Available January 1, 1969. Only \$60,000. Write Department 541, PENNSYLVANIA MEDICINE.

FOR RENT

Ski House for rent—Sugarbush Vermont, five bedrooms, fireplace, modern facilities, sleeps eleven, by season, month or week. Write Box 54, Ridley Park, Pa. 19078.

CLASSIFIED ADVERTISING INFORMATION

RATES—\$10.00 per insertion up to 30 words; 40 cents each additional word; \$1.00 per insertion for answers sent in care of Pennsylvania Medical Society. Payable in advance.

COPY DEADLINE—Copy due by the first day of month preceding month of publication. Send to Pennsylvania Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pennsylvania 17043. The right is reserved to reject or modify copy to conform with publication rules.

DEPARTMENT NUMBERS—Advertisers using department numbers forbid disclosure of their identity. Written inquiries are forwarded to such advertisers.

WORD COUNT—Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one, and "Write Department . . . , Pennsylvania Medicine," as five.

WETHERHOLD
AND
METZGER Famous Shoes

**WE'RE
SPECIALISTS
IN FITTING
"SPECIAL" FEET**



THE
STRIDE RITE
SHOE

**Orthopedic Fitting and
Orthopedic shoes always in stock**

—ALLENTOWN—

• UP-TOWN STORES
953 Hamilton St.
951 Hamilton St.

• CENTRAL STORE
719 Hamilton St.



The Physician's Faith

An objective analysis of scientific medicine suggests that over the centuries we have progressively become more and more adept at eliminating the impediments to healing. Although great advances have been made in the science of medicine, it is plain enough that apart from the fact of healing, we could do nothing.

Indeed, the happiness known by all physicians unconsciously stems from our privilege to participate in one of life's great mysteries, that of healing.

I sometimes wonder, however, if the modern physician is not frequently tempted to overlook this truth. Indeed, we can "cure" so much, prevent so much, and replace so much, that we are vainly tempted to accept the credit and encumber ourselves with the anxieties of the indispensable man. He who permits this to occur deprives himself of the profession's greatest rewards.

In spite of this temptation to which we are all subject, physicians do look forward to the exciting pleasures of each day's adventure, rejoice in their privilege to participate in the fact of healing and unconsciously rely on its mysterious eventuality.

Hebrews 11:1 states "Now Faith is the substance of things hoped for, the evidence of things not seen." I sometimes suspect we have more Faith than we realize.

As a rural family physician, I am not infrequently impressed by the joy, peace of mind and contentment of

the farmer. Though confronted daily by economic perplexities, the vicissitudes of nature and hard work, he derives a degree of satisfaction and pleasure from his vocation unmatched by most others.

An objective analysis of the experience of the farmer reveals that when the planting is finished, he sleeps and rises as though in calm reliance on a power beyond himself.

Although great advances have been made in the science of farming, there is no restlessness, no feverish effort, no forcing of results. To be sure, there is work to be done each day, never any escape from responsibility; but he is never vain to think that it all depends on himself and is free of the anxieties of the "indispensable" man.

It is plain enough that without the seed, the soil, the rain and the sun, he can do nothing. "The earth bringeth forth fruit of itself" and with this measure of security the farmer is a participant in one of life's great mysteries.

As a family physician, I am similarly impressed by the pleasures and satisfactions enjoyed by medical doctors from the sophisticated ivory towers to the least auspicious back woods practice. Though confronted daily by political perplexities, the vicissitudes of human nature, and hard work, we derive a degree of satisfaction and pleasure from our vocation that I would suspect exceeds most others.

Robert Poole, M.D., Chairman
PMS Medicine & Religion Committee

Advertiser's Index

Albert Einstein Medical Center	70	Merck, Sharp and Dohme	19
Bertholon Rowland Agencies	64	National Conference on Rural Health	69
Breon Laboratories	74	Parke, Davis and Co.	9
Brown Pharmaceutical Co	65	Pennsylvania Society for Colon and Rectal Surgery	69
Burroughs-Wellcome	49	Pitman-Moore	80, Third Cover
Coca Cola Bottling Co.	71	Poythress, William P. and Co.	30
Conal Pharmaceuticals	67	Robins, A. H. Co.	12, 31
First Investment Annuity Co. of America	33	Roche Laboratories	17, Fourth Cover
Geigy Pharmaceuticals	6, 7, 8, 50, 51	Roerig, J. B. Co.	23
Highland Hospital	71	Sandoz Pharmaceuticals	21
Hynson, Wescott and Dunning	1	Searle, G. D. and Co.	78, 79
International Pharmaceutical Corp.	28, 29	Smith, Kline and French	73
Lederle Laboratories	3, 22, 31, 52	Strasenburg Pharmaceuticals	24
Lehigh County Medical Society	15	Stuart Company	77
Lilly, Eli and Co.	10, 11, 36, 54, 55, 56	Warrensville State Hospital	63
Medical Protective Co.	74	Wetherhold and Metzger	75

the ^{In peptic ulcer:} antacid puzzle



solved by
Mylanta[®]
aluminum and magnesium hydroxides plus simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta also contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients — after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.



Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

No two women are
quite alike...



and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968^{1,2} estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy,

migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: *Brit. Med. J.* 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: *Brit. Med. J.* 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Novahistine Singlet is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief. Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and aches and pains that almost always accompany upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine[®]
Singlet decongestant-
analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)



*ready
for bed...*



*but not
for
sleep*

**...because psychic tension
may not stop at night**

The calming action of Valium (diazepam) helps counteract psychic tension and reduce overreaction to stresses during the day. Often the t.i.d. dosage schedule is enough to prevent build-up of tenseness that may interfere with sleep at night.

However, when psychic tension does contribute to sleeplessness, Valium can be especially useful. A tablet at bedtime, added to the daytime t.i.d. dosage, can help your patient be ready for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely

depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium[®]
(diazepam)



Roche[®]
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110







COUNTWAY LIBRARY



HC 4KBW A

